

SENATE
STATE OF MINNESOTA
SPECIAL SESSION

S.F. No. 2

(SENATE AUTHORS: BENSON and Abeler)

DATE
05/24/2017

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Introduction and first reading

OFFICIAL STATUS

1.1 A bill for an act

1.2 relating to state government; establishing the health and human services budget;

1.3 modifying provisions governing community supports, housing, continuing care,

1.4 health care, health insurance, direct care and treatment, children and families,

1.5 chemical and mental health services, Department of Human Services operations,

1.6 Health Department, health licensing boards, opiate abuse prevention, managed

1.7 care organizations, and child care development block grant compliance; making

1.8 technical changes; modifying terminology and definitions; establishing licensing

1.9 fix-it tickets; requiring reports; establishing moratorium on conversion transactions;

1.10 modifying fees; making forecast adjustments; appropriating money; amending

1.11 Minnesota Statutes 2016, sections 3.972, by adding subdivisions; 13.32, by adding

1.12 a subdivision; 13.46, subdivisions 1, 2; 13.84, subdivision 5; 62A.04, subdivision

1.13 1; 62A.21, subdivision 2a; 62A.3075; 62D.105; 62E.04, subdivision 11; 62E.05,

1.14 subdivision 1; 62E.06, by adding a subdivision; 62K.15; 62U.02; 103I.005,

1.15 subdivisions 2, 2a, 12, 20a, 21, by adding subdivisions; 103I.101, subdivisions 2,

1.16 5, 6; 103I.105; 103I.111, subdivisions 6, 8; 103I.205, subdivisions 1, 2, 3, 4, 5, 6;

1.17 103I.208, subdivisions 1, 2; 103I.235, by adding a subdivision; 103I.301,

1.18 subdivisions 1, 2; 103I.315, subdivision 1; 103I.501; 103I.505, subdivisions 1, 2;

1.19 103I.515; 103I.525, subdivisions 1, 2, 5, 6, 8; 103I.531, subdivisions 2, 5; 103I.535,

1.20 subdivisions 2, 6; 103I.541, subdivisions 1, 2, 2a, 2b, 2c, 2e, 3, 4, 5; 103I.545;

1.21 103I.601, subdivisions 2, 4; 103I.711, subdivision 1; 103I.715, subdivision 2;

1.22 119B.011, subdivisions 20, 20a; 119B.025, subdivision 1, by adding subdivisions;

1.23 119B.03, subdivision 3; 119B.05, subdivision 1; 119B.09, subdivisions 1, 4;

1.24 119B.10, subdivision 1, by adding a subdivision; 119B.12, subdivision 2; 119B.13,

1.25 subdivisions 1, 6; 144.0722, subdivision 1, as amended; 144.0724, subdivisions

1.26 4, 6; 144.122; 144.1501, subdivision 2; 144.4961, subdivisions 3, 4, 5; 144.551,

1.27 subdivision 1; 144.562, subdivision 2; 144.99, subdivision 1; 144A.071,

1.28 subdivisions 3, as amended, 4a, as amended, 4c, as amended, 4d, as amended;

1.29 144A.10, subdivision 4, as amended; 144A.351, subdivision 1; 144A.472,

1.30 subdivision 7; 144A.4799, subdivision 3; 144A.70, subdivision 6, by adding a

1.31 subdivision; 144A.74; 144D.04, subdivision 2, by adding a subdivision; 144D.06;

1.32 145.4131, subdivision 1; 145.4716, subdivision 2; 145.928, subdivision 13; 145.986,

1.33 subdivision 1a; 146B.02, subdivisions 2, 3, 5, 8, by adding subdivisions; 146B.03,

1.34 subdivisions 6, 7, as amended; 146B.07, subdivision 2; 146B.10, subdivisions 1,

1.35 2, by adding a subdivision; 147.01, subdivision 7; 147.02, subdivision 1; 147.03,

1.36 subdivision 1; 147B.08, by adding a subdivision; 147C.40, by adding a subdivision;

1.37 148.514, subdivision 1; 148.519, subdivisions 1, 2; 148.5194, subdivisions 2, 3,

1.38 4, 7, by adding a subdivision; 148.5195, subdivision 2; 148.6402, subdivision 4;

1.39 148.6405; 148.6408, subdivision 2; 148.6410, subdivision 2; 148.6412, subdivision

2.1 2; 148.6415; 148.6418, subdivisions 1, 2, 4, 5; 148.6420, subdivisions 1, 3, 5;
2.2 148.6423; 148.6425, subdivisions 2, 3; 148.6428; 148.6443, subdivisions 5, 6, 7,
2.3 8; 148.6445, subdivisions 1, 10; 148.6448; 148.881; 148.89; 148.90, subdivisions
2.4 1, 2; 148.905, subdivision 1; 148.907, subdivisions 1, 2; 148.9105, subdivisions
2.5 1, 4, 5; 148.916, subdivisions 1, 1a; 148.925; 148.96, subdivision 3; 148.997,
2.6 subdivision 1; 148B.53, subdivision 1; 150A.06, subdivisions 3, 8; 150A.10,
2.7 subdivision 4; 151.212, subdivision 2; 152.11, by adding a subdivision; 152.25,
2.8 subdivision 1, by adding subdivisions; 152.28, by adding a subdivision; 152.33,
2.9 by adding a subdivision; 153A.14, subdivisions 1, 2; 153A.17; 157.16, subdivisions
2.10 1, 3, 3a; 214.01, subdivision 2; 245.462, subdivision 9; 245.467, subdivision 2;
2.11 245.4871, by adding subdivisions; 245.4876, subdivision 2; 245.4889, subdivision
2.12 1; 245.814, by adding a subdivision; 245.91, subdivisions 4, 6; 245.94, subdivision
2.13 1; 245.97, subdivision 6; 245A.02, subdivisions 2b, 5a, by adding subdivisions;
2.14 245A.03, subdivisions 2, 7; 245A.04, subdivisions 4, 14; 245A.06, subdivisions
2.15 2, 8, by adding a subdivision; 245A.07, subdivision 3; 245A.09, subdivision 7;
2.16 245A.10, subdivision 2; 245A.11, by adding subdivisions; 245A.14, by adding a
2.17 subdivision; 245A.16, subdivision 1, by adding a subdivision; 245A.191; 245A.40,
2.18 by adding a subdivision; 245A.50, subdivision 5; 245C.02, by adding a subdivision;
2.19 245C.03, subdivision 1, by adding a subdivision; 245C.04, subdivisions 1, 8;
2.20 245C.05, subdivisions 2b, 4, 5, 7; 245C.08, subdivisions 1, 2, 4; 245C.09, by
2.21 adding a subdivision; 245C.10, subdivision 9, by adding subdivisions; 245C.11,
2.22 subdivision 3; 245C.15; 245C.16, subdivision 1; 245C.17, subdivision 6; 245C.21,
2.23 subdivision 1; 245C.22, subdivisions 5, 7; 245C.23; 245C.24, subdivision 3;
2.24 245C.25; 245C.30, subdivision 2; 245D.03, subdivision 1; 245D.04, subdivision
2.25 3; 246.18, subdivision 4, by adding a subdivision; 252.27, subdivision 2a; 252.41,
2.26 subdivision 3; 252.50, subdivision 5; 253B.10, subdivision 1; 254A.01; 254A.02,
2.27 subdivisions 2, 3, 5, 6, 8, 10, by adding subdivisions; 254A.03; 254A.035,
2.28 subdivision 1; 254A.04; 254A.08; 254A.09; 254A.19, subdivision 3; 254B.01,
2.29 subdivision 3, by adding a subdivision; 254B.03, subdivision 2; 254B.04,
2.30 subdivisions 1, 2b; 254B.05, subdivisions 1, 1a, 5; 254B.051; 254B.07; 254B.08;
2.31 254B.09; 254B.12, subdivision 2, by adding a subdivision; 254B.13, subdivision
2.32 2a; 256.01, by adding a subdivision; 256.045, subdivisions 3, 3a; 256.9657,
2.33 subdivision 1; 256.9685, subdivisions 1, 1a; 256.9686, subdivision 8; 256.969,
2.34 subdivisions 1, 2b, 3a, 8, 8c, 9, 12; 256.9695, subdivision 1; 256.975, subdivision
2.35 7, by adding a subdivision; 256B.04, subdivisions 12, 24; 256B.056, subdivisions
2.36 3b, 3c, 5c; 256B.0561, subdivisions 2, 4; 256B.057, subdivision 9, as amended;
2.37 256B.059, subdivision 6, as amended; 256B.0621, subdivision 10; 256B.0625,
2.38 subdivisions 1, 3b, 6a, 7, 17, 17b, 18h, 20, 31, 45a, 64, by adding subdivisions;
2.39 256B.0644; 256B.0653, subdivisions 2, 3, 4, as amended, 5, 6, by adding a
2.40 subdivision; 256B.072; 256B.0755, subdivisions 1, 3, 4, by adding a subdivision;
2.41 256B.0911, subdivisions 1a, 2b, 3a, 4d, as amended, 5, 6, as amended, by adding
2.42 a subdivision; 256B.0915, subdivisions 1, 3a, 3e, 3h, 5, by adding subdivisions;
2.43 256B.092, subdivision 4; 256B.0921; 256B.0924, by adding a subdivision;
2.44 256B.0943, subdivision 13; 256B.0945, subdivisions 2, 4; 256B.196, subdivisions
2.45 2, 3, 4; 256B.35, subdivision 4, as amended; 256B.431, subdivisions 10, 16, 30;
2.46 256B.434, subdivisions 4, 4f; 256B.49, subdivisions 11, 15; 256B.4913, subdivision
2.47 4a, by adding a subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 16, by
2.48 adding a subdivision; 256B.493, subdivisions 1, 2, by adding a subdivision;
2.49 256B.50, subdivision 1b; 256B.5012, by adding subdivisions; 256B.69, subdivision
2.50 9e, by adding subdivisions; 256B.75; 256B.76, subdivisions 1, as amended, 2;
2.51 256B.761; 256B.763; 256B.766; 256C.21; 256C.23, subdivisions 1, 2, by adding
2.52 subdivisions; 256C.233, subdivisions 1, 2, 4; 256C.24; 256C.25, subdivision 1;
2.53 256C.261; 256C.30; 256D.44, subdivisions 4, as amended, 5, as amended; 256E.30,
2.54 subdivision 2; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2d, 2g, 3; 256I.05,
2.55 subdivisions 1a, 1c, 1e, 1j, 1m, by adding subdivisions; 256I.06, subdivisions 2,
2.56 8; 256J.45, subdivision 2; 256L.03, subdivisions 1, 1a, 5; 256L.11, subdivision 7,
2.57 by adding a subdivision; 256L.15, subdivision 2; 256P.06, subdivision 2; 256P.07,
2.58 subdivisions 3, 6; 256R.02, subdivisions 4, 17, 18, 19, 22, 42, 52, by adding

3.1 subdivisions; 256R.06, subdivision 5; 256R.07, by adding a subdivision; 256R.10,
 3.2 by adding a subdivision; 256R.37; 256R.40, subdivisions 1, 5; 256R.41; 256R.47;
 3.3 256R.49, subdivision 1; 260C.451, subdivision 6; 327.15, subdivision 3; 364.09;
 3.4 609.5315, subdivision 5c; 626.556, subdivisions 2, 3, 3c, 4, 10d, 10e, 10f, 10i;
 3.5 Laws 2009, chapter 101, article 1, section 12; Laws 2012, chapter 247, article 4,
 3.6 section 47, as amended; article 6, section 2, subdivision 2; Laws 2013, chapter
 3.7 108, article 15, section 2, subdivision 2; Laws 2015, chapter 71, article 14, section
 3.8 3, subdivision 2, as amended; Laws 2017, chapter 2, article 1, sections 2,
 3.9 subdivision 3; 5; 7; Laws 2017, chapter 13, article 1, section 15; proposing coding
 3.10 for new law in Minnesota Statutes, chapters 103I; 119B; 137; 144; 147A; 148;
 3.11 245; 245A; 256; 256B; 256I; 256N; 256R; proposing coding for new law as
 3.12 Minnesota Statutes, chapters 144H; 245G; repealing Minnesota Statutes 2016,
 3.13 sections 13.468; 103I.005, subdivisions 8, 14, 15; 103I.451; 119B.07; 144.0571;
 3.14 144A.351, subdivision 2; 147A.21; 147B.08, subdivisions 1, 2, 3; 147C.40,
 3.15 subdivisions 1, 2, 3, 4; 148.6402, subdivision 2; 148.6450; 148.906; 148.907,
 3.16 subdivision 5; 148.908; 148.909, subdivision 7; 148.96, subdivisions 4, 5;
 3.17 245A.1915; 245A.192; 254A.02, subdivision 4; 256B.19, subdivision 1c;
 3.18 256B.4914, subdivision 16; 256B.64; 256B.7631; Laws 2012, chapter 247, article
 3.19 4, section 47, as amended; Laws 2015, chapter 71, article 7, section 54; Minnesota
 3.20 Rules, parts 5600.2500; 9500.1140, subparts 3, 4, 5, 6; 9530.6405, subparts 1, 1a,
 3.21 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18,
 3.22 20, 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430;
 3.23 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465;
 3.24 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500;
 3.25 9530.6505.

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

3.27 **ARTICLE 1**

3.28 **COMMUNITY SUPPORTS**

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

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

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

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

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

- 4.1 (i) changes in availability of the range of long-term care services and housing options;
- 4.2 (ii) access problems, including access to the least restrictive and most integrated services
- 4.3 and settings, regarding long-term care services; and
- 4.4 (iii) comparative measures of long-term care services availability, including serving
- 4.5 people in their home areas near family, and changes over time; and
- 4.6 (4) recommendations regarding goals for the future of long-term care services and
- 4.7 supports, policy and fiscal changes, and resource development and transition needs.

4.8 Sec. 2. Minnesota Statutes 2016, section 245D.03, subdivision 1, is amended to read:

4.9 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home

4.10 and community-based services to persons with disabilities and persons age 65 and older

4.11 pursuant to this chapter. The licensing standards in this chapter govern the provision of

4.12 basic support services and intensive support services.

4.13 (b) Basic support services provide the level of assistance, supervision, and care that is

4.14 necessary to ensure the health and welfare of the person and do not include services that

4.15 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the

4.16 person. Basic support services include:

4.17 (1) in-home and out-of-home respite care services as defined in section 245A.02,

4.18 subdivision 15, and under the brain injury, community alternative care, community access

4.19 for disability inclusion, developmental disability, and elderly waiver plans, excluding

4.20 out-of-home respite care provided to children in a family child foster care home licensed

4.21 under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license

4.22 holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,

4.23 or successor provisions; and section 245D.061 or successor provisions, which must be

4.24 stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000,

4.25 subpart 4;

4.26 (2) adult companion services as defined under the brain injury, community access for

4.27 disability inclusion, and elderly waiver plans, excluding adult companion services provided

4.28 under the Corporation for National and Community Services Senior Companion Program

4.29 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

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

4.31 (4) 24-hour emergency assistance, personal emergency response as defined under the

4.32 community access for disability inclusion and developmental disability waiver plans;

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

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

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

5.7 (c) Intensive support services provide assistance, supervision, and care that is necessary
5.8 to ensure the health and welfare of the person and services specifically directed toward the
5.9 training, habilitation, or rehabilitation of the person. Intensive support services include:

5.10 (1) intervention services, including:

5.11 (i) behavioral support services as defined under the brain injury and community access
5.12 for disability inclusion waiver plans;

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

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

5.17 (2) in-home support services, including:

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

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

5.22 (iii) semi-independent living services; and

5.23 (iv) individualized home supports services as defined under the brain injury, community
5.24 alternative care, and community access for disability inclusion waiver plans;

5.25 (3) residential supports and services, including:

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

5.29 (ii) foster care services as defined in the brain injury, community alternative care, and
5.30 community access for disability inclusion waiver plans provided in a family or corporate

6.1 child foster care residence, a family adult foster care residence, or a community residential
6.2 setting; and

6.3 (iii) residential services provided to more than four persons with developmental
6.4 disabilities in a supervised living facility, including ICFs/DD;

6.5 (4) day services, including:

6.6 (i) structured day services as defined under the brain injury waiver plan;

6.7 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
6.8 under the developmental disability waiver plan; and

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

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

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

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

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

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

6.25 Sec. 3. Minnesota Statutes 2016, section 252.41, subdivision 3, is amended to read:

6.26 Subd. 3. **Day training and habilitation services for adults with developmental**
6.27 **disabilities.** (a) "Day training and habilitation services for adults with developmental
6.28 disabilities" means services that:

6.29 (1) include supervision, training, assistance, ~~and supported employment,~~ center-based
6.30 work-related activities, or other community-integrated activities designed and implemented
6.31 in accordance with the individual service and individual habilitation plans required under

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

7.4 (2) are provided by a vendor licensed under sections 245A.01 to 245A.16 and 252.28,
 7.5 subdivision 2, to provide day training and habilitation services.

7.6 (b) Day training and habilitation services reimbursable under this section do not include
 7.7 special education and related services as defined in the Education of the Individuals with
 7.8 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17),
 7.9 or vocational services funded under section 110 of the Rehabilitation Act of 1973, United
 7.10 States Code, title 29, section 720, as amended.

7.11 (c) Day training and habilitation services do not include employment exploration,
 7.12 employment development, or employment support services as defined in the home and
 7.13 community-based services waivers for people with disabilities authorized under sections
 7.14 256B.092 and 256B.49.

7.15 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 7.16 of human services shall notify the revisor of statutes when federal approval is obtained.

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

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

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

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

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

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

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

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

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

8.4 Subd. 6a. **Home health services.** Home health services are those services specified in
8.5 Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance
8.6 covers home health services at a recipient's home residence or in the community where
8.7 normal life activities take the recipient. Medical assistance does not cover home health
8.8 services for residents of a hospital, nursing facility, or intermediate care facility, unless the
8.9 commissioner of human services has authorized skilled nurse visits for less than 90 days
8.10 for a resident at an intermediate care facility for persons with developmental disabilities,
8.11 to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise
8.12 eligible is on leave from the facility and the facility either pays for the home health services
8.13 or forgoes the facility per diem for the leave days that home health services are used. Home
8.14 health services must be provided by a Medicare certified home health agency. All nursing
8.15 and home health aide services must be provided according to sections 256B.0651 to
8.16 256B.0653.

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

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

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

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

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

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

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

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

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

9.10 (1) can withstand repeated use;

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

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

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

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

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

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

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

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

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

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

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

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

10.11 (f) "Occupational therapy services" mean the services defined in Minnesota Rules, part
10.12 9505.0390.

10.13 (g) "Physical therapy services" mean the services defined in Minnesota Rules, part
10.14 9505.0390.

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

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

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

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

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

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

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

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

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

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

11.15 Sec. 9. Minnesota Statutes 2016, section 256B.0653, subdivision 4, as amended by Laws
11.16 2017, chapter 59, section 10, is amended to read:

11.17 Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided
11.18 by a registered nurse or a licensed practical nurse under the supervision of a registered nurse,
11.19 according to the written plan of care and accepted standards of medical and nursing practice
11.20 according to chapter 148. Skilled nurse visit services must be ordered by a physician,
11.21 advanced practice registered nurse, or physician assistant and documented in a plan of care
11.22 that is reviewed and approved by the ordering physician, advanced practice registered nurse,
11.23 or physician assistant at least once every 60 days. All skilled nurse visits must be medically
11.24 necessary and provided in the recipient's home residence or in the community where normal
11.25 life activities take the recipient, except as allowed under section 256B.0625, subdivision
11.26 6a.

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

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

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

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

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

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

12.14 (b) Home care therapies must be:

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

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

12.20 (3) assessed by an appropriate therapist; and

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

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

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

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

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

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

13.4 (2) the following skilled nurse visits:

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

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

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

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

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

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

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

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

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

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

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

- 14.1 face-to-face encounter may be conducted by one of the following practitioners, licensed in
- 14.2 Minnesota:
- 14.3 (1) a physician;
- 14.4 (2) a nurse practitioner or clinical nurse specialist;
- 14.5 (3) a certified nurse midwife; or
- 14.6 (4) a physician assistant.
- 14.7 (b) The allowed nonphysician practitioner, as described in this subdivision, performing
- 14.8 the face-to-face encounter must communicate the clinical findings of that face-to-face
- 14.9 encounter to the ordering physician. Those clinical findings must be incorporated into a
- 14.10 written or electronic document included in the recipient's medical record. To assure clinical
- 14.11 correlation between the face-to-face encounter and the associated home health services, the
- 14.12 physician responsible for ordering the services must:
- 14.13 (1) document that the face-to-face encounter, which is related to the primary reason the
- 14.14 recipient requires home health services, occurred within the required time period; and
- 14.15 (2) indicate the practitioner who conducted the encounter and the date of the encounter.
- 14.16 (c) For home health services requiring authorization, including prior authorization, home
- 14.17 health agencies must retain the qualifying documentation of a face-to-face encounter as part
- 14.18 of the recipient health service record, and submit the qualifying documentation to the
- 14.19 commissioner or the commissioner's designee upon request.
- 14.20 Sec. 13. Minnesota Statutes 2016, section 256B.0911, subdivision 1a, is amended to read:
- 14.21 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:
- 14.22 (a) Until additional requirements apply under paragraph (b), "long-term care consultation
- 14.23 services" means:
- 14.24 (1) intake for and access to assistance in identifying services needed to maintain an
- 14.25 individual in the most inclusive environment;
- 14.26 (2) providing recommendations for and referrals to cost-effective community services
- 14.27 that are available to the individual;
- 14.28 (3) development of an individual's person-centered community support plan;
- 14.29 (4) providing information regarding eligibility for Minnesota health care programs;

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

15.4 (6) determination of home and community-based waiver and other service eligibility as
15.5 required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
15.6 determination for individuals who need an institutional level of care as determined under
15.7 subdivision 4e, based on assessment and community support plan development, appropriate
15.8 referrals to obtain necessary diagnostic information, and including an eligibility determination
15.9 for consumer-directed community supports;

15.10 (7) providing recommendations for institutional placement when there are no
15.11 cost-effective community services available;

15.12 (8) providing access to assistance to transition people back to community settings after
15.13 institutional admission; and

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

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

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

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

15.26 (ii) consumer support grants under section 256.476; or

15.27 (iii) section 256B.85;

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

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

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

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

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

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

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

16.15 (f) "Person-centered planning" is a process that includes the active participation of a
 16.16 person in the planning of the person's services, including in making meaningful and informed
 16.17 choices about the person's own goals, talents, and objectives, as well as making meaningful
 16.18 and informed choices about the services the person receives. For the purposes of this section,
 16.19 "informed choice" means a voluntary choice of services by a person from all available
 16.20 service options based on accurate and complete information concerning all available service
 16.21 options and concerning the person's own preferences, abilities, goals, and objectives. In
 16.22 order for a person to make an informed choice, all available options must be developed and
 16.23 presented to the person to empower the person to make decisions.

16.24 Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 2b, is amended to read:

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

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

17.3 Certified assessors are responsible for:

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

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

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

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

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

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

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

17.20 **Subd. 3f. Long-term care reassessments and community support plan updates.**

17.21 Reassessments must be tailored using the professional judgment of the assessor to the
17.22 person's known needs, strengths, preferences, and circumstances. Reassessments provide
17.23 information to support the person's informed choice and opportunities to express choice
17.24 regarding activities that contribute to quality of life, as well as information and opportunity
17.25 to identify goals related to desired employment, community activities, and preferred living
17.26 environment. Reassessments allow for a review of the current support plan's effectiveness,
17.27 monitoring of services, and the development of an updated person-centered community
17.28 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
17.29 and provide an opportunity for quality assurance of service delivery. Face-to-face assessments
17.30 must be conducted annually or as required by federal and state laws and rules.

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

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

18.7 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing
18.8 facility must be screened prior to admission according to the requirements outlined in section
18.9 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as
18.10 required under section 256.975, subdivision 7.

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

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

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

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

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

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

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

19.9 (j) Funding for preadmission screening follow-up shall be provided to the Disability
19.10 Linkage Line for the under-60 population by the Department of Human Services to cover
19.11 options counseling salaries and expenses to provide the services described in subdivisions
19.12 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to
19.13 employ, within the limits of available funding, sufficient personnel to provide preadmission
19.14 screening follow-up services and shall seek to maximize federal funding for the service as
19.15 provided under section 256.01, subdivision 2, paragraph (aa).

19.16 Sec. 17. Minnesota Statutes 2016, section 256B.0911, subdivision 5, is amended to read:

19.17 Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes,
19.18 including timelines for when assessments need to be completed, required to provide the
19.19 services in this section and shall implement integrated solutions to automate the business
19.20 processes to the extent necessary for community support plan approval, reimbursement,
19.21 program planning, evaluation, and policy development.

19.22 (b) The commissioner of human services shall work with lead agencies responsible for
19.23 conducting long-term consultation services to modify the MnCHOICES application and
19.24 assessment policies to create efficiencies while ensuring federal compliance with medical
19.25 assistance and long-term services and supports eligibility criteria.

19.26 Sec. 18. Minnesota Statutes 2016, section 256B.0911, subdivision 6, as amended by Laws
19.27 2017, chapter 40, article 1, section 70, is amended to read:

19.28 Subd. 6. **Payment for long-term care consultation services.** (a) Until September 30,
19.29 2013, payment for long-term care consultation face-to-face assessment shall be made as
19.30 described in this subdivision.

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

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

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

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

20.14 (e) Payments for long-term care consultation services are available to the county or
20.15 counties to cover staff salaries and expenses to provide the services described in subdivision
20.16 1a. The county shall employ, or contract with other agencies to employ, within the limits
20.17 of available funding, sufficient personnel to provide long-term care consultation services
20.18 while meeting the state's long-term care outcomes and objectives as defined in subdivision
20.19 1. The county shall be accountable for meeting local objectives as approved by the
20.20 commissioner in the biennial home and community-based services quality assurance plan
20.21 on a form provided by the commissioner.

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

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

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

20.31 (i) The commissioner shall develop an alternative payment methodology, effective on
20.32 October 1, 2013, for long-term care consultation services that includes the funding available
20.33 under this subdivision, and for assessments authorized under sections 256B.092 and
20.34 256B.0659. In developing the new payment methodology, the commissioner shall consider

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

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

21.9 **256B.0921 HOME AND COMMUNITY-BASED SERVICES INCENTIVE POOL.**

21.10 The commissioner of human services shall develop an initiative to provide incentives
 21.11 for innovation in: (1) achieving integrated competitive employment;; (2) achieving integrated
 21.12 competitive employment for youth under age 25 upon their graduation from school; (3)
 21.13 living in the most integrated setting; and (4) other outcomes determined by the commissioner.
 21.14 The commissioner shall seek requests for proposals and shall contract with one or more
 21.15 entities to provide incentive payments for meeting identified outcomes. ~~The initial requests~~
 21.16 ~~for proposals must be issued by October 1, 2016.~~

21.17 Sec. 20. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

21.18 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
 21.19 "implementation period" means the period beginning January 1, 2014, and ending on the
 21.20 last day of the month in which the rate management system is populated with the data
 21.21 necessary to calculate rates for substantially all individuals receiving home and
 21.22 community-based waiver services under sections 256B.092 and 256B.49. "Banding period"
 21.23 means the time period beginning on January 1, 2014, and ending upon the expiration of the
 21.24 12-month period defined in paragraph (c), clause (5).

21.25 (b) For purposes of this subdivision, the historical rate for all service recipients means
 21.26 the individual reimbursement rate for a recipient in effect on December 1, 2013, except
 21.27 that:

21.28 (1) for a day service recipient who was not authorized to receive these waiver services
 21.29 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
 21.30 changed providers on or after January 1, 2014, the historical rate must be the weighted
 21.31 average authorized rate for the provider number in the county of service, effective December
 21.32 1, 2013; or

22.1 (2) for a unit-based service with programming or a unit-based service without
22.2 programming recipient who was not authorized to receive these waiver services prior to
22.3 January 1, 2014; added a new service or services on or after January 1, 2014; or changed
22.4 providers on or after January 1, 2014, the historical rate must be the weighted average
22.5 authorized rate for each provider number in the county of service, effective December 1,
22.6 2013; or

22.7 (3) for residential service recipients who change providers on or after January 1, 2014,
22.8 the historical rate must be set by each lead agency within their county aggregate budget
22.9 using their respective methodology for residential services effective December 1, 2013, for
22.10 determining the provider rate for a similarly situated recipient being served by that provider.

22.11 (c) The commissioner shall adjust individual reimbursement rates determined under this
22.12 section so that the unit rate is no higher or lower than:

22.13 (1) 0.5 percent from the historical rate for the implementation period;

22.14 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately
22.15 following the time period of clause (1);

22.16 (3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately
22.17 following the time period of clause (2);

22.18 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately
22.19 following the time period of clause (3);

22.20 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately
22.21 following the time period of clause (4); ~~and~~

22.22 (6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately
22.23 following the time period of clause (5). During this banding rate period, the commissioner
22.24 shall not enforce any rate decrease or increase that would otherwise result from the end of
22.25 the banding period. The commissioner shall, upon enactment, seek federal approval for the
22.26 addition of this banding period; and

22.27 (7) one percent from the rate in effect in clause (6) for the 12-month period immediately
22.28 following the time period of clause (6).

22.29 (d) The commissioner shall review all changes to rates that were in effect on December
22.30 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service
22.31 unit utilization on an annual basis as those in effect on October 31, 2013.

23.1 (e) By December 31, 2014, the commissioner shall complete the review in paragraph
 23.2 (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

23.3 (f) During the banding period, the Medicaid Management Information System (MMIS)
 23.4 service agreement rate must be adjusted to account for change in an individual's need. The
 23.5 commissioner shall adjust the Medicaid Management Information System (MMIS) service
 23.6 agreement rate by:

23.7 (1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the
 23.8 individual with variables reflecting the level of service in effect on December 1, 2013;

23.9 (2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the
 23.10 individual with variables reflecting the updated level of service at the time of application;
 23.11 and

23.12 (3) adding to or subtracting from the Medicaid Management Information System (MMIS)
 23.13 service agreement rate, the difference between the values in clauses (1) and (2).

23.14 (g) This subdivision must not apply to rates for recipients served by providers new to a
 23.15 given county after January 1, 2014. Providers of personal supports services who also acted
 23.16 as fiscal support entities must be treated as new providers as of January 1, 2014.

23.17 **EFFECTIVE DATE.** (a) The amendment to paragraph (b) is effective the day following
 23.18 final enactment.

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

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

23.23 **Subd. 7. New services.** A service added to section 256B.4914 after January 1, 2014, is
 23.24 not subject to rate stabilization adjustment in this section.

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

23.26 Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 2, is amended to read:

23.27 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
 23.28 meanings given them, unless the context clearly indicates otherwise.

23.29 (b) "Commissioner" means the commissioner of human services.

24.1 (c) "Component value" means underlying factors that are part of the cost of providing
24.2 services that are built into the waiver rates methodology to calculate service rates.

24.3 (d) "Customized living tool" means a methodology for setting service rates that delineates
24.4 and documents the amount of each component service included in a recipient's customized
24.5 living service plan.

24.6 (e) "Disability waiver rates system" means a statewide system that establishes rates that
24.7 are based on uniform processes and captures the individualized nature of waiver services
24.8 and recipient needs.

24.9 (f) "Individual staffing" means the time spent as a one-to-one interaction specific to an
24.10 individual recipient by staff to provide direct support and assistance with activities of daily
24.11 living, instrumental activities of daily living, and training to participants, and is based on
24.12 the requirements in each individual's coordinated service and support plan under section
24.13 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
24.14 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
24.15 needs must also be considered.

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

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

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

24.22 (j) "Rates management system" means a Web-based software application that uses a
24.23 framework and component values, as determined by the commissioner, to establish service
24.24 rates.

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

24.27 (l) "Shared staffing" means time spent by employees, not defined under paragraph (f),
24.28 providing or available to provide more than one individual with direct support and assistance
24.29 with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph
24.30 (b); instrumental activities of daily living as defined under section 256B.0659, subdivision
24.31 1, paragraph (i); ancillary activities needed to support individual services; and training to
24.32 participants, and is based on the requirements in each individual's coordinated service and
24.33 support plan under section 245D.02, subdivision 4b; any coordinated service and support

25.1 plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider
25.2 observation of an individual's service need. Total shared staffing hours are divided
25.3 proportionally by the number of individuals who receive the shared service provisions.

25.4 (m) "Staffing ratio" means the number of recipients a service provider employee supports
25.5 during a unit of service based on a uniform assessment tool, provider observation, case
25.6 history, and the recipient's services of choice, and not based on the staffing ratios under
25.7 section 245D.31.

25.8 (n) "Unit of service" means the following:

25.9 (1) for residential support services under subdivision 6, a unit of service is a day. Any
25.10 portion of any calendar day, within allowable Medicaid rules, where an individual spends
25.11 time in a residential setting is billable as a day;

25.12 (2) for day services under subdivision 7:

25.13 (i) for day training and habilitation services, a unit of service is either:

25.14 (A) a day unit of service is defined as six or more hours of time spent providing direct
25.15 services and transportation; or

25.16 (B) a partial day unit of service is defined as fewer than six hours of time spent providing
25.17 direct services and transportation; and

25.18 (C) for new day service recipients after January 1, 2014, 15 minute units of service must
25.19 be used for fewer than six hours of time spent providing direct services and transportation;

25.20 (ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A
25.21 day unit of service is six or more hours of time spent providing direct services;

25.22 (iii) for prevocational services, a unit of service is a day or an hour. A day unit of service
25.23 is six or more hours of time spent providing direct service;

25.24 (3) for unit-based services with programming under subdivision 8:

25.25 (i) for supported living services, a unit of service is a day or 15 minutes. When a day
25.26 rate is authorized, any portion of a calendar day where an individual receives services is
25.27 billable as a day; and

25.28 (ii) for all other services, a unit of service is 15 minutes; and

25.29 (4) for unit-based services without programming under subdivision 9:

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

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

26.5 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 26.6 of human services shall notify the revisor of statutes when federal approval is obtained.

26.7 Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

26.8 Subd. 3. **Applicable services.** Applicable services are those authorized under the state's
 26.9 home and community-based services waivers under sections 256B.092 and 256B.49,
 26.10 including the following, as defined in the federally approved home and community-based
 26.11 services plan:

26.12 (1) 24-hour customized living;

26.13 (2) adult day care;

26.14 (3) adult day care bath;

26.15 (4) behavioral programming;

26.16 (5) companion services;

26.17 (6) customized living;

26.18 (7) day training and habilitation;

26.19 (8) housing access coordination;

26.20 (9) independent living skills;

26.21 (10) in-home family support;

26.22 (11) night supervision;

26.23 (12) personal support;

26.24 (13) prevocational services;

26.25 (14) residential care services;

26.26 (15) residential support services;

26.27 (16) respite services;

26.28 (17) structured day services;

27.1 (18) supported employment services;

27.2 (19) supported living services;

27.3 (20) transportation services; ~~and~~

27.4 (21) individualized home supports;

27.5 (22) independent living skills specialist services;

27.6 (23) employment exploration services;

27.7 (24) employment development services;

27.8 (25) employment support services; and

27.9 ~~(21)~~ (26) other services as approved by the federal government in the state home and
27.10 community-based services plan.

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

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

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

27.16 Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

27.17 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
27.18 is established to determine staffing costs associated with providing services to individuals
27.19 receiving home and community-based services. For purposes of developing and calculating
27.20 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
27.21 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
27.22 the most recent edition of the Occupational Handbook must be used. The base wage index
27.23 must be calculated as follows:

27.24 (1) for residential direct care staff, the sum of:

27.25 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
27.26 health aide (SOC code 39-9021); 30 percent of the median wage for nursing ~~aide~~ assistant
27.27 (SOC code ~~31-1012~~ 31-1014); and 20 percent of the median wage for social and human
27.28 services aide (SOC code 21-1093); and

27.29 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
27.30 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide

28.1 (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code
 28.2 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
 28.3 29-2053); and 20 percent of the median wage for social and human services aide (SOC code
 28.4 21-1093);

28.5 (2) for day services, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code
 28.6 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
 28.7 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
 28.8 21-1093);

28.9 (3) for residential asleep-overnight staff, the wage ~~will be \$7.66 per hour~~ is the minimum
 28.10 wage in Minnesota for large employers, except in a family foster care setting, the wage is
 28.11 ~~\$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

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

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

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

28.18 (7) for supportive living services staff, 20 percent of the median wage for nursing ~~aide~~
 28.19 assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric
 28.20 technician (SOC code 29-2053); and 60 percent of the median wage for social and human
 28.21 services aide (SOC code 21-1093);

28.22 (8) for housing access coordination staff, ~~50~~ 100 percent of the median wage for
 28.23 community and social services specialist (SOC code 21-1099); ~~and 50 percent of the median~~
 28.24 ~~wage for social and human services aide (SOC code 21-1093);~~

28.25 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
 28.26 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
 28.27 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
 28.28 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
 28.29 code 29-2053);

28.30 (10) for individualized home supports services staff, 40 percent of the median wage for
 28.31 community social service specialist (SOC code 21-1099); 50 percent of the median wage
 28.32 for social and human services aide (SOC code 21-1093); and ten percent of the median
 28.33 wage for psychiatric technician (SOC code 29-2053);

29.1 (11) for independent living skills staff, 40 percent of the median wage for community
 29.2 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
 29.3 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
 29.4 technician (SOC code 29-2053);

29.5 (12) for independent living skills specialist staff, 100 percent of mental health and
 29.6 substance abuse social worker (SOC code 21-1023);

29.7 ~~(11)~~ (13) for supported employment staff, 20 percent of the median wage for nursing
 29.8 ~~aide assistant~~ (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric
 29.9 technician (SOC code 29-2053); and 60 percent of the median wage for social and human
 29.10 services aide (SOC code 21-1093);

29.11 (14) for employment support services staff, 50 percent of the median wage for
 29.12 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
 29.13 community and social services specialist (SOC code 21-1099);

29.14 (15) for employment exploration services staff, 50 percent of the median wage for
 29.15 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
 29.16 community and social services specialist (SOC code 21-1099);

29.17 (16) for employment development services staff, 50 percent of the median wage for
 29.18 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
 29.19 of the median wage for community and social services specialist (SOC code 21-1099);

29.20 ~~(12)~~ (17) for adult companion staff, 50 percent of the median wage for personal and
 29.21 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides,~~
 29.22 ~~orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

29.23 ~~(13)~~ (18) for night supervision staff, 20 percent of the median wage for home health
 29.24 aide (SOC code 31-1011); 20 percent of the median wage for personal and home health
 29.25 aide (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC
 29.26 code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC
 29.27 code 29-2053); and 20 percent of the median wage for social and human services aide (SOC
 29.28 code 21-1093);

29.29 ~~(14)~~ (19) for respite staff, 50 percent of the median wage for personal and home care
 29.30 aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies,~~
 29.31 ~~and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

30.1 ~~(15)~~ (20) for personal support staff, 50 percent of the median wage for personal and
 30.2 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
 30.3 ~~orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

30.4 ~~(16)~~ (21) for supervisory staff, ~~the basic wage is \$17.43 per hour,~~ 100 percent of the
 30.5 median wage for community and social services specialist (SOC code 21-1099), with the
 30.6 exception of the supervisor of behavior professional, behavior analyst, and behavior
 30.7 specialists, which must be \$30.75 per hour is 100 percent of the median wage for clinical
 30.8 counseling and school psychologist (SOC code 19-3031);

30.9 ~~(17)~~ (22) for registered nurse staff, ~~the basic wage is \$30.82 per hour,~~ 100 percent of
 30.10 the median wage for registered nurses (SOC code 29-1141); and

30.11 ~~(18)~~ (23) for licensed practical nurse staff, ~~the basic wage is \$18.64 per hour~~ 100 percent
 30.12 of the median wage for licensed practical nurses (SOC code 29-2061).

30.13 (b) Component values for residential support services are:

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

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

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

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

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

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

30.20 (c) Component values for family foster care are:

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

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

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

30.24 (4) general administrative support ratio: 3.3 percent;

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

30.26 (6) absence factor: 1.7 percent.

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

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

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

- 31.1 (3) employee-related cost ratio: 23.6 percent;
- 31.2 (4) program plan support ratio: 5.6 percent;
- 31.3 (5) client programming and support ratio: ten percent;
- 31.4 (6) general administrative support ratio: 13.25 percent;
- 31.5 (7) program-related expense ratio: 1.8 percent; and
- 31.6 (8) absence and utilization factor ratio: ~~3.9~~ 9.4 percent.
- 31.7 (e) Component values for unit-based services with programming are:
- 31.8 (1) supervisory span of control ratio: 11 percent;
- 31.9 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 31.10 (3) employee-related cost ratio: 23.6 percent;
- 31.11 (4) program plan supports ratio: ~~3.4~~ 15.5 percent;
- 31.12 (5) client programming and supports ratio: ~~8.6~~ 4.7 percent;
- 31.13 (6) general administrative support ratio: 13.25 percent;
- 31.14 (7) program-related expense ratio: 6.1 percent; and
- 31.15 (8) absence and utilization factor ratio: 3.9 percent.
- 31.16 (f) Component values for unit-based services without programming except respite are:
- 31.17 (1) supervisory span of control ratio: 11 percent;
- 31.18 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 31.19 (3) employee-related cost ratio: 23.6 percent;
- 31.20 (4) program plan support ratio: ~~3.4~~ 7.0 percent;
- 31.21 (5) client programming and support ratio: ~~8.6~~ 2.3 percent;
- 31.22 (6) general administrative support ratio: 13.25 percent;
- 31.23 (7) program-related expense ratio: ~~6.4~~ 2.9 percent; and
- 31.24 (8) absence and utilization factor ratio: 3.9 percent.
- 31.25 (g) Component values for unit-based services without programming for respite are:
- 31.26 (1) supervisory span of control ratio: 11 percent;
- 31.27 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

- 32.1 (3) employee-related cost ratio: 23.6 percent;
- 32.2 (4) general administrative support ratio: 13.25 percent;
- 32.3 (5) program-related expense ratio: ~~6.4~~ 2.9 percent; and
- 32.4 (6) absence and utilization factor ratio: 3.9 percent.

32.5 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph

32.6 (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor

32.7 Statistics available on December 31, 2016. The commissioner shall publish these updated

32.8 values and load them into the rate management system. ~~This adjustment occurs every five~~

32.9 ~~years. For adjustments in 2021 and beyond, the commissioner shall use the data available~~

32.10 ~~on December 31 of the calendar year five years prior. On July 1, 2022, and every five years~~

32.11 thereafter, the commissioner shall update the base wage index in paragraph (a) based on

32.12 the most recently available wage data by SOC from the Bureau of Labor Statistics. The

32.13 commissioner shall publish these updated values and load them into the rate management

32.14 system.

32.15 (i) On July 1, 2017, the commissioner shall update the framework components in

32.16 ~~paragraphs (b) to (g)~~ paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f),

32.17 clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17),

32.18 for changes in the Consumer Price Index. The commissioner will adjust these values higher

32.19 or lower by the percentage change in the Consumer Price Index-All Items, United States

32.20 city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall

32.21 publish these updated values and load them into the rate management system. ~~This adjustment~~

32.22 ~~occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use~~

32.23 ~~the data available on January 1 of the calendar year four years prior and January 1 of the~~

32.24 ~~current calendar year. On July 1, 2022, and every five years thereafter, the commissioner~~

32.25 shall update the framework components in paragraph (d), clause (5); paragraph (e), clause

32.26 (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7,

32.27 clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner

32.28 shall adjust these values higher or lower by the percentage change in the CPI-U from the

32.29 date of the previous update to the date of the data most recently available prior to the

32.30 scheduled update. The commissioner shall publish these updated values and load them into

32.31 the rate management system.

32.32 (j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer

32.33 Price Index items are unavailable in the future, the commissioner shall recommend to the

32.34 legislature codes or items to update and replace missing component values.

33.1 **EFFECTIVE DATE.** (a) The amendments to paragraphs (a) to (g) are effective January
33.2 1, 2018, except the amendment to paragraph (a), clauses (3), (21), and (22), and paragraph
33.3 (d), clause (8), which are effective January 1, 2019, and the amendment to paragraph (a),
33.4 clause (10), which is effective the day following final enactment.

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

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

33.9 Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

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

33.13 (1) determine the number of shared staffing and individual direct staff hours to meet a
33.14 recipient's needs provided on site or through monitoring technology;

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

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

33.21 (4) multiply the number of shared and individual direct staff hours provided on site or
33.22 through monitoring technology and nursing hours by the appropriate staff wages in
33.23 subdivision 5, paragraph (a), or the customized direct-care rate;

33.24 (5) multiply the number of shared and individual direct staff hours provided on site or
33.25 through monitoring technology and nursing hours by the product of the supervision span
33.26 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
33.27 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

33.28 (6) combine the results of clauses (4) and (5), excluding any shared and individual direct
33.29 staff hours provided through monitoring technology, and multiply the result by one plus
33.30 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
33.31 clause (2). This is defined as the direct staffing cost;

34.1 (7) for employee-related expenses, multiply the direct staffing cost, excluding any shared
34.2 and individual direct staff hours provided through monitoring technology, by one plus the
34.3 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

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

34.5 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
34.6 customized for adapted transport, based on the resident with the highest assessed need.

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

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

34.11 (2) sum the standard general and administrative rate, the program-related expense ratio,
34.12 and the absence and utilization ratio;

34.13 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
34.14 payment amount; and

34.15 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
34.16 adjust for regional differences in the cost of providing services.

34.17 (c) The payment methodology for customized living, 24-hour customized living, and
34.18 residential care services must be the customized living tool. Revisions to the customized
34.19 living tool must be made to reflect the services and activities unique to disability-related
34.20 recipient needs.

34.21 (d) For individuals enrolled prior to January 1, 2014, the days of service authorized must
34.22 meet or exceed the days of service used to convert service agreements in effect on December
34.23 1, 2013, and must not result in a reduction in spending or service utilization due to conversion
34.24 during the implementation period under section 256B.4913, subdivision 4a. If during the
34.25 implementation period, an individual's historical rate, including adjustments required under
34.26 section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate
34.27 determined in this subdivision, the number of days authorized for the individual is 365.

34.28 (e) The number of days authorized for all individuals enrolling after January 1, 2014,
34.29 in residential services must include every day that services start and end.

35.1 Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:

35.2 Subd. 7. **Payments for day programs.** Payments for services with day programs
35.3 including adult day care, day treatment and habilitation, prevocational services, and structured
35.4 day services must be calculated as follows:

35.5 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:

35.6 (i) the staffing ratios for the units of service provided to a recipient in a typical week
35.7 must be averaged to determine an individual's staffing ratio; and

35.8 (ii) the commissioner, in consultation with service providers, shall develop a uniform
35.9 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

35.10 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
35.11 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
35.12 5;

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

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

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

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

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

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

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

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

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

36.2 (12) this is the subtotal rate;

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

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

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

36.9 (16) for transportation provided as part of day training and habilitation for an individual
36.10 who does not require a lift, add:

36.11 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
36.12 a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a
36.13 vehicle with a lift;

36.14 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
36.15 a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a
36.16 vehicle with a lift;

36.17 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
36.18 a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a
36.19 vehicle with a lift; or

36.20 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
36.21 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
36.22 with a lift;

36.23 (17) for transportation provided as part of day training and habilitation for an individual
36.24 who does require a lift, add:

36.25 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
36.26 lift, and \$15.05 for a shared ride in a vehicle with a lift;

36.27 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
36.28 lift, and \$28.16 for a shared ride in a vehicle with a lift;

36.29 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
36.30 lift, and \$58.76 for a shared ride in a vehicle with a lift; or

37.1 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
37.2 and \$80.93 for a shared ride in a vehicle with a lift.

37.3 Sec. 27. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

37.4 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
37.5 services with programming, including behavior programming, housing access coordination,
37.6 in-home family support, independent living skills training, independent living skills specialist
37.7 services, individualized home supports, hourly supported living services, employment
37.8 exploration services, employment development services, supported employment, and
37.9 ~~supported employment~~ support services provided to an individual outside of any day or
37.10 residential service plan must be calculated as follows, unless the services are authorized
37.11 separately under subdivision 6 or 7:

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

37.13 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
37.14 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
37.15 5;

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

37.19 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
37.20 5, paragraph (a), or the customized direct-care rate;

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

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

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

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

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

38.1 (10) this is the subtotal rate;

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

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

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

38.13 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
38.14 to adjust for regional differences in the cost of providing services.

38.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.
38.16 Supported employment services in this subdivision expire upon federal approval. The
38.17 commissioner of human services shall notify the revisor of statutes when federal approval
38.18 is obtained.

38.19 Sec. 28. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

38.20 **Subd. 9. Payments for unit-based services without programming.** Payments for
38.21 unit-based services without programming, including night supervision, personal support,
38.22 respite, and companion care provided to an individual outside of any day or residential
38.23 service plan must be calculated as follows unless the services are authorized separately
38.24 under subdivision 6 or 7:

38.25 (1) for all services except respite, determine the number of units of service to meet a
38.26 recipient's needs;

38.27 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
38.28 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

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

39.1 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
39.2 5 or the customized direct care rate;

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

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

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

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

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

39.15 (10) this is the subtotal rate;

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

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

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

39.22 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
39.23 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

39.24 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
39.25 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
39.26 is defined as the customized direct care rate;

39.27 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
39.28 5, paragraph (a);

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

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

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

40.6 (20) this is the subtotal rate;

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

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

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

40.13 Sec. 29. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

40.14 Subd. 10. **Updating payment values and additional information.** (a) From January
40.15 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform
40.16 procedures to refine terms and adjust values used to calculate payment rates in this section.

40.17 (b) No later than July 1, 2014, the commissioner shall, within available resources, begin
40.18 to conduct research and gather data and information from existing state systems or other
40.19 outside sources on the following items:

40.20 (1) differences in the underlying cost to provide services and care across the state; and

40.21 (2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and
40.22 units of transportation for all day services, which must be collected from providers using
40.23 the rate management worksheet and entered into the rates management system; and

40.24 (3) the distinct underlying costs for services provided by a license holder under sections
40.25 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
40.26 by a license holder certified under section 245D.33.

40.27 (c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid
40.28 set of rates management system data, the commissioner, in consultation with stakeholders,
40.29 shall analyze for each service the average difference in the rate on December 31, 2013, and
40.30 the framework rate at the individual, provider, lead agency, and state levels. The
40.31 commissioner shall issue semiannual reports to the stakeholders on the difference in rates
40.32 by service and by county during the banding period under section 256B.4913, subdivision

41.1 4a. The commissioner shall issue the first report by October 1, 2014, and the final report
 41.2 shall be issued by December 31, 2018.

41.3 (d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall
 41.4 begin the review and evaluation of the following values already in subdivisions 6 to 9, or
 41.5 issues that impact all services, including, but not limited to:

41.6 (1) values for transportation rates ~~for day services;~~

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

41.8 ~~(3)~~ (2) values for services where monitoring technology replaces staff time;

41.9 ~~(4)~~ (3) values for indirect services;

41.10 ~~(5)~~ (4) values for nursing;

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

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

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

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

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

41.16 ~~(11)~~ (5) values for the facility use rate in day services, and the weightings used in the
 41.17 day service ratios and adjustments to those weightings;

41.18 ~~(12)~~ (6) values for workers' compensation as part of employee-related expenses;

41.19 ~~(13)~~ (7) values for unemployment insurance as part of employee-related expenses;

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

41.23 ~~(15)~~ (8) any changes in state or federal law with ~~an~~ a direct impact on the underlying
 41.24 cost of providing home and community-based services; and

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

41.27 (e) The commissioner shall report to the chairs and the ranking minority members of
 41.28 the legislative committees and divisions with jurisdiction over health and human services
 41.29 policy and finance with the information and data gathered under paragraphs (b) to (d) on
 41.30 the following dates:

42.1 (1) January 15, 2015, with preliminary results and data;

42.2 (2) January 15, 2016, with a status implementation update, and additional data and
42.3 summary information;

42.4 (3) January 15, 2017, with the full report; and

42.5 (4) January 15, ~~2019~~ 2020, with another full report, and a full report once every four
42.6 years thereafter.

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

42.12 ~~(g)~~ (f) The commissioner shall implement a regional adjustment factor to all rate
42.13 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July
42.14 1, 2017, the commissioner shall renew analysis and implement changes to the regional
42.15 adjustment factors when adjustments required under subdivision 5, paragraph (h), occur.
42.16 Prior to implementation, the commissioner shall consult with stakeholders on the
42.17 methodology to calculate the adjustment.

42.18 ~~(h)~~ (g) The commissioner shall provide a public notice via LISTSERV in October of
42.19 each year beginning October 1, 2014, containing information detailing legislatively approved
42.20 changes in:

42.21 (1) calculation values including derived wage rates and related employee and
42.22 administrative factors;

42.23 (2) service utilization;

42.24 (3) county and tribal allocation changes; and

42.25 (4) information on adjustments made to calculation values and the timing of those
42.26 adjustments.

42.27 The information in this notice must be effective January 1 of the following year.

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

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

43.3 ~~(j)~~ (h) When the available shared staffing hours in a residential setting are insufficient
 43.4 to meet the needs of an individual who enrolled in residential services after January 1, 2014,
 43.5 or insufficient to meet the needs of an individual with a service agreement adjustment
 43.6 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours
 43.7 shall be used.

43.8 (i) The commissioner shall study the underlying cost of absence and utilization for day
 43.9 services. Based on the commissioner's evaluation of the data collected under this paragraph,
 43.10 the commissioner shall make recommendations to the legislature by January 15, 2018, for
 43.11 changes, if any, to the absence and utilization factor ratio component value for day services.

43.12 (j) Beginning July 1, 2017, the commissioner shall collect transportation and trip
 43.13 information for all day services through the rates management system.

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

43.15 Sec. 30. Minnesota Statutes 2016, section 256B.4914, is amended by adding a subdivision
 43.16 to read:

43.17 **Subd. 10a. Reporting and analysis of cost data.** (a) The commissioner must ensure
 43.18 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
 43.19 service. As determined by the commissioner, in consultation with stakeholders identified
 43.20 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates
 43.21 determined under this section must submit requested cost data to the commissioner to support
 43.22 research on the cost of providing services that have rates determined by the disability waiver
 43.23 rates system. Requested cost data may include, but is not limited to:

43.24 (1) worker wage costs;

43.25 (2) benefits paid;

43.26 (3) supervisor wage costs;

43.27 (4) executive wage costs;

43.28 (5) vacation, sick, and training time paid;

43.29 (6) taxes, workers' compensation, and unemployment insurance costs paid;

43.30 (7) administrative costs paid;

43.31 (8) program costs paid;

44.1 (9) transportation costs paid;

44.2 (10) vacancy rates; and

44.3 (11) other data relating to costs required to provide services requested by the
44.4 commissioner.

44.5 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
44.6 year that ended not more than 18 months prior to the submission date. The commissioner
44.7 shall provide each provider a 90-day notice prior to its submission due date. If a provider
44.8 fails to submit required reporting data, the commissioner shall provide notice to providers
44.9 that have not provided required data 30 days after the required submission date, and a second
44.10 notice for providers who have not provided required data 60 days after the required
44.11 submission date. The commissioner shall temporarily suspend payments to the provider if
44.12 cost data is not received 90 days after the required submission date. Withheld payments
44.13 shall be made once data is received by the commissioner.

44.14 (c) The commissioner shall conduct a random validation of data submitted under
44.15 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
44.16 in paragraph (a) and provide recommendations for adjustments to cost components.

44.17 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
44.18 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
44.19 recommendations on component values and inflationary factor adjustments to the chairs
44.20 and ranking minority members of the legislative committees with jurisdiction over human
44.21 services every four years beginning January 1, 2020. The commissioner shall make
44.22 recommendations in conjunction with reports submitted to the legislature according to
44.23 subdivision 10, paragraph (e). The commissioner shall release cost data in an aggregate
44.24 form, and cost data from individual providers shall not be released except as provided for
44.25 in current law.

44.26 (e) The commissioner, in consultation with stakeholders identified in section 256B.4913,
44.27 subdivision 5, shall develop and implement a process for providing training and technical
44.28 assistance necessary to support provider submission of cost documentation required under
44.29 paragraph (a).

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

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

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

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

45.3 (1) for residential services: 1.003;

45.4 (2) for day services: 1.000;

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

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

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

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

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

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

45.24 **256C.21 DEAF AND HARD-OF-HEARING SERVICES ACT; CITATION.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47.25 (3) ~~provide a coordinated system of statewide interpreting or interpreter referral services~~
 47.26 oversee and manage grant-funded services for persons who are deaf, persons who are
 47.27 deafblind, and persons who are hard-of-hearing and a person's family as provided in sections
 47.28 237.23, 256C.25, 256C.261, 256C.30 and as appropriated by the legislature; and

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

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

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

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

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

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

48.13 **256C.24 REGIONAL SERVICE CENTERS SERVICES.**

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

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

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

48.31 (i) teaching communication strategies and coping skills;

48.32 (ii) offering guidance and problem solving assistance;

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

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

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

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

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

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

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

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

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

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

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

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

50.1 ~~(9)~~ (6) assess the ongoing need and supply of services for persons who are deaf, persons
 50.2 who are deafblind, and persons who are hard-of-hearing persons in all parts of the state and
 50.3 cooperate with public and private service providers to develop these services.

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

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

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

50.10 Subd. 3. **Advisory committee.** The director of the Deaf and Hard-of-Hearing Services
 50.11 Division shall appoint ~~an advisory committee~~ eight advisory committees of up to nine
 50.12 persons ~~for each regional service area~~ per advisory committee. Each committee shall represent
 50.13 a specific region of the state. The director shall determine the boundaries of each advisory
 50.14 committee region. The committees shall advise the director on the needs of persons who
 50.15 are deaf, persons who are deafblind, and persons who are hard-of-hearing and service gaps
 50.16 in the region of the state the committee represents. Members shall include persons who are
 50.17 deaf, persons who are deafblind, and persons who are hard-of-hearing, persons who have
 50.18 communication disabilities, parents of children who are deaf and parents of children who
 50.19 are hard-of-hearing, parents of children who have communication disabilities, and
 50.20 representatives of county and regional human services, including representatives of private
 50.21 service providers. At least 50 percent of the members must be deaf or deafblind or
 50.22 hard-of-hearing or have a communication disability. Committee members shall serve for a
 50.23 three-year term and shall serve no more than two consecutive terms, and may be appointed
 50.24 to consecutive terms. Each advisory committee shall elect a chair. The director of the Deaf
 50.25 and Hard-of-Hearing Services Division shall assign staff to serve as nonvoting members of
 50.26 the committee. Members shall not receive a per diem. Otherwise, the compensation, removal
 50.27 of members, and filling of vacancies on the committee shall be as provided in section
 50.28 15.0575.

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

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

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

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

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

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

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

51.13 **256C.261 SERVICES FOR A PERSON WHO IS DEAFBLIND PERSONS.**

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

51.23 The commissioner shall award grants for the purposes of:

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

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

51.30 (b) The commissioner may make grants:

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

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

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

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

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

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

52.7 **256C.30 DUTIES OF HUMAN SERVICES COMMISSIONER.**

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

52.12 (b) The grant agreements must provide for:

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

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

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

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

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

52.24 Sec. 44. Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter
52.25 312, article 27, section 72, and Laws 2016, chapter 144, section 1, the effective date, is
52.26 amended to read:

52.27 **EFFECTIVE DATE.** ~~The amendments to this section are effective on June 1, 2016,~~
52.28 ~~and expire on the date Laws 2015, chapter 71, article 7, section 54, becomes effective. The~~
52.29 ~~commissioner of human services shall notify the revisor of statutes when Laws 2015, chapter~~
52.30 ~~71, article 7, section 54, becomes effective. Notwithstanding any other law to the contrary,~~
52.31 the exception in this section is effective until the exception under section 44 or under Laws

53.1 2015, chapter 71, article 7, section 54, becomes effective, whichever occurs first. The
53.2 commissioner of human services shall notify the revisor of statutes when section 44 or Laws
53.3 2015, chapter 71, article 7, section 54, is effective.

53.4 **Sec. 45. EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS**
53.5 **BUDGET METHODOLOGY EXCEPTION.**

53.6 (a) No later than September 30, 2017, if necessary, the commissioner of human services
53.7 shall submit an amendment to the Centers for Medicare and Medicaid Services for the home
53.8 and community-based services waivers authorized under Minnesota Statutes, sections
53.9 256B.092 and 256B.49, to expand the exception to the consumer-directed community
53.10 supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide
53.11 up to 30 percent more funds for either:

53.12 (1) consumer-directed community supports participants who have a coordinated service
53.13 and support plan which identifies the need for an increased amount of services or supports
53.14 under consumer-directed community supports than the amount they are currently receiving
53.15 under the consumer-directed community supports budget methodology:

53.16 (i) to increase the amount of time a person works or otherwise improves employment
53.17 opportunities;

53.18 (ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes,
53.19 section 256D.44, subdivision 5, paragraph (f), clause (1), item (ii), or paragraph (g); or

53.20 (iii) to develop and implement a positive behavior support plan; or

53.21 (2) home and community-based waiver participants who are currently using licensed
53.22 providers for (i) employment supports or services during the day; or (ii) residential services,
53.23 either of which cost more annually than the person would spend under a consumer-directed
53.24 community supports plan for any or all of the supports needed to meet the goals identified
53.25 in paragraph (a), clause (1), items (i), (ii), and (iii).

53.26 (b) The exception under paragraph (a), clause (1), is limited to those persons who can
53.27 demonstrate that they will have to discontinue using consumer-directed community supports
53.28 and accept other non-self-directed waiver services because their supports needed for the
53.29 goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within
53.30 the consumer-directed community supports budget limits.

53.31 (c) The exception under paragraph (a), clause (2), is limited to those persons who can
53.32 demonstrate that, upon choosing to become a consumer-directed community supports

54.1 participant, the total cost of services, including the exception, will be less than the cost of
 54.2 current waiver services.

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

54.9 **Sec. 46. CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
 54.10 **METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND**
 54.11 **CRISIS RESIDENTIAL SETTINGS.**

54.12 (a) By September 30, 2017, the commissioner shall establish an institutional and crisis
 54.13 bed consumer-directed community supports budget exception process in the home and
 54.14 community-based services waivers under Minnesota Statutes, sections 256B.092 and
 54.15 256B.49. This budget exception process shall be available for any individual who:

54.16 (1) is not offered available and appropriate services within 60 days since approval for
 54.17 discharge from the individual's current institutional setting; and

54.18 (2) requires services that are more expensive than appropriate services provided in a
 54.19 noninstitutional setting using the consumer-directed community supports option.

54.20 (b) Institutional settings for purposes of this exception include intermediate care facilities
 54.21 for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka
 54.22 Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget
 54.23 exception shall be limited to no more than the amount of appropriate services provided in
 54.24 a noninstitutional setting as determined by the lead agency managing the individual's home
 54.25 and community-based services waiver. The lead agency shall notify the Department of
 54.26 Human Services of the budget exception.

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

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

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

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

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

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

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

55.17 The commissioner of human services shall submit necessary waiver amendments to the
 55.18 Centers for Medicare and Medicaid Services to add employment exploration services,
 55.19 employment development services, and employment support services to the home and
 55.20 community-based services waivers authorized under Minnesota Statutes, sections 256B.092
 55.21 and 256B.49. The commissioner shall also submit necessary waiver amendments to remove
 55.22 community-based employment services from day training and habilitation and prevocational
 55.23 services. The commissioner shall submit all necessary waiver amendments by October 1,
 55.24 2017.

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

55.26 Sec. 49. **TRANSPORTATION STUDY.**

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

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

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

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

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

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

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

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

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

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

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

56.20 (1) reduce assessment times;

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

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

56.26 (4) evaluate alternative payment methods.

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

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

57.1 determine whether random moment is efficient and effective in supporting functions of
 57.2 assessment and support planning and the purpose under Minnesota Statutes, section
 57.3 256B.0911, subdivision 1. The commissioner shall submit a report to the chairs and ranking
 57.4 minority members of the house of representatives and senate committees with jurisdiction
 57.5 over health and human services by January 15, 2019. The report must provide
 57.6 recommendations for changes to payment methodologies and functions related to assessment,
 57.7 eligibility determination, and support planning.

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

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

57.15 (b) The rate changes described in this section apply to direct support services provided
 57.16 through a covered program, as defined by Minnesota Statutes, section 256B.0711, subdivision
 57.17 1, paragraph (b).

57.18 **Sec. 53. REPEALER.**

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

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

57.22 (c) Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter
 57.23 312, article 27, section 72, Laws 2015, chapter 71, article 7, section 58, Laws 2016, chapter
 57.24 144, section 1; and Laws 2015, chapter 71, article 7, section 54, are repealed upon the
 57.25 effective date of section 44.

57.26 **ARTICLE 2**

57.27 **HOUSING**

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

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

- 58.1 (1) the name, street address, and mailing address of the establishment;
- 58.2 (2) the name and mailing address of the owner or owners of the establishment and, if
58.3 the owner or owners is not a natural person, identification of the type of business entity of
58.4 the owner or owners;
- 58.5 (3) the name and mailing address of the managing agent, through management agreement
58.6 or lease agreement, of the establishment, if different from the owner or owners;
- 58.7 (4) the name and address of at least one natural person who is authorized to accept service
58.8 of process on behalf of the owner or owners and managing agent;
- 58.9 (5) a statement describing the registration and licensure status of the establishment and
58.10 any provider providing health-related or supportive services under an arrangement with the
58.11 establishment;
- 58.12 (6) the term of the contract;
- 58.13 (7) a description of the services to be provided to the resident in the base rate to be paid
58.14 by resident, including a delineation of the portion of the base rate that constitutes rent and
58.15 a delineation of charges for each service included in the base rate;
- 58.16 (8) a description of any additional services, including home care services, available for
58.17 an additional fee from the establishment directly or through arrangements with the
58.18 establishment, and a schedule of fees charged for these services;
- 58.19 (9) a description of the process through which the contract may be modified, amended,
58.20 or terminated, including whether a move to a different room or sharing a room would be
58.21 required in the event that the tenant can no longer pay the current rent;
- 58.22 (10) a description of the establishment's complaint resolution process available to residents
58.23 including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;
- 58.24 (11) the resident's designated representative, if any;
- 58.25 (12) the establishment's referral procedures if the contract is terminated;
- 58.26 (13) requirements of residency used by the establishment to determine who may reside
58.27 or continue to reside in the housing with services establishment;
- 58.28 (14) billing and payment procedures and requirements;
- 58.29 (15) a statement regarding the ability of ~~residents~~ a resident to receive services from
58.30 service providers with whom the establishment does not have an arrangement;

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

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

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

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

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

59.19 (b) The contract must include a statement:

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

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

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

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

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

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

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

60.2 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
60.3 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
60.4 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
60.5 for a physical location that will not be the primary residence of the license holder for the
60.6 entire period of licensure. If a license is issued during this moratorium, and the license
60.7 holder changes the license holder's primary residence away from the physical location of
60.8 the foster care license, the commissioner shall revoke the license according to section
60.9 245A.07. The commissioner shall not issue an initial license for a community residential
60.10 setting licensed under chapter 245D. Exceptions to the moratorium include:

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

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

60.16 (3) new foster care licenses or community residential setting licenses determined to be
60.17 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
60.18 or regional treatment center; restructuring of state-operated services that limits the capacity
60.19 of state-operated facilities; or allowing movement to the community for people who no
60.20 longer require the level of care provided in state-operated facilities as provided under section
60.21 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

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

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

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

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

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

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

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

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

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

62.1 inform the Department of Human Services Licensing Division. The department ~~shall~~ may
62.2 decrease the statewide licensed capacity for adult foster care settings ~~where the physical~~
62.3 ~~location is not the primary residence of the license holder, or for adult community residential~~
62.4 ~~settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the~~
62.5 ~~savings required by reductions in licensed bed capacity under Laws 2011, First Special~~
62.6 ~~Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term~~
62.7 ~~care residential services capacity within budgetary limits. Implementation of the statewide~~
62.8 ~~licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense~~
62.9 ~~up to 128 beds by June 30, 2014, using the needs determination process. Prior to any~~
62.10 ~~involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies~~
62.11 ~~and license holders to determine which adult foster care settings, where the physical location~~
62.12 ~~is not the primary residence of the license holder, or community residential settings, are~~
62.13 ~~licensed for up to five beds, but have operated at less than full capacity for 12 or more~~
62.14 ~~months as of March 1, 2014. The settings that meet these criteria must be the first to be~~
62.15 ~~considered for an involuntary decrease in statewide licensed capacity, up to a maximum of~~
62.16 ~~35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall~~
62.17 ~~prioritize the selection of those beds to be closed based on the length of time the beds have~~
62.18 ~~been vacant. The longer a bed has been vacant, the higher priority it must be given for~~
62.19 ~~closure. Under this paragraph, the commissioner has the authority to reduce unused licensed~~
62.20 ~~capacity of a current foster care program, or the community residential settings, to accomplish~~
62.21 ~~the consolidation or closure of settings. Under this paragraph, the commissioner has the~~
62.22 ~~authority to manage statewide capacity, including adjusting the capacity available to each~~
62.23 ~~county and adjusting statewide available capacity, to meet the statewide needs identified~~
62.24 ~~through the process in paragraph (e). A decreased licensed capacity according to this~~
62.25 ~~paragraph is not subject to appeal under this chapter.~~

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

62.30 (e) A resource need determination process, managed at the state level, using the available
62.31 reports required by section 144A.351, and other data and information shall be used to
62.32 determine where the reduced capacity ~~required~~ determined under ~~paragraph (e)~~ section
62.33 256B.493 will be implemented. The commissioner shall consult with the stakeholders
62.34 described in section 144A.351, and employ a variety of methods to improve the state's
62.35 capacity to meet the informed decisions of those people who want to move out of corporate

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

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

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

63.24 (h) The commissioner may adjust capacity to address needs identified in section
63.25 144A.351. Under this authority, the commissioner may approve new licensed settings or
63.26 delicense existing settings. Delicensing of settings will be accomplished through a process
63.27 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
63.28 information and data on capacity of licensed long-term services and supports, actions taken
63.29 under the subdivision to manage statewide long-term services and supports resources, and
63.30 any recommendations for change to the legislative committees with jurisdiction over the
63.31 health and human services budget.

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

64.1 inform the license holder of its right to request reconsideration by the commissioner. The
64.2 license holder's request for reconsideration must be in writing. If mailed, the request for
64.3 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
64.4 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
64.5 reconsideration is made by personal service, it must be received by the commissioner within
64.6 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

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

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

64.21 (b) The license holder shall:

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

64.24 (2) document the provision of this training; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

66.24 (14) be free from maltreatment;

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

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

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

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

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

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

67.5 (c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8),
67.6 (10), and (11), is allowed only if determined necessary to ensure the health, safety, and
67.7 well-being of the resident. Any restriction of a resident's right must be documented and
67.8 justified in the resident's individual abuse prevention plan required by sections 245A.65,
67.9 subdivision 2, paragraph (b) and 626.557, subdivision 14. For a resident served under section
67.10 256B.0915, the case manager must be part of the interdisciplinary team under section
67.11 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least
67.12 restrictive manner necessary to protect the resident and provide support to reduce or eliminate
67.13 the need for the restriction.

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

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

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

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

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

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

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

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

67.32 (4) the program was not paid for services;

68.1 (5) the program ceases to operate; or

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

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

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

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

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

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

68.17 (1) the reason for the action;

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

68.21 (3) the resident's right to appeal the service termination under section 256.045, subdivision
68.22 3, paragraph (a); and

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

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

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

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

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

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

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

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

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

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

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

69.11 (3) be free from maltreatment;

69.12 (4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited
69.13 procedure identified in section 245D.06, subdivision 5, or successor provisions, except for:

69.14 (i) emergency use of manual restraint to protect the person from imminent danger to self
69.15 or others according to the requirements in section 245D.061 or successor provisions; or (ii)
69.16 the use of safety interventions as part of a positive support transition plan under section
69.17 245D.06, subdivision 8, or successor provisions;

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

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

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

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

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

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

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

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

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

70.6 (14) personal privacy; and

70.7 (15) engage in chosen activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

71.17 (2) any patient or relative aggrieved by an order of the commissioner under section
 71.18 252.27;

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

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

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

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

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

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

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

72.4 (10) except as provided under chapter 245C, an individual disqualified under sections
 72.5 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23,
 72.6 on the basis of serious or recurring maltreatment; a preponderance of the evidence that the
 72.7 individual has committed an act or acts that meet the definition of any of the crimes listed
 72.8 in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section
 72.9 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment
 72.10 determination under clause (4) or (9) and a disqualification under this clause in which the
 72.11 basis for a disqualification is serious or recurring maltreatment, shall be consolidated into
 72.12 a single fair hearing. In such cases, the scope of review by the human services judge shall
 72.13 include both the maltreatment determination and the disqualification. The failure to exercise
 72.14 the right to an administrative reconsideration shall not be a bar to a hearing under this section
 72.15 if federal law provides an individual the right to a hearing to dispute a finding of
 72.16 maltreatment;

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

72.22 (12) a person issued a notice of service termination under section 245D.10, subdivision
 72.23 3a, from residential supports and services as defined in section 245D.03, subdivision 1,
 72.24 paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; ~~or~~

72.25 (13) an individual disability waiver recipient based on a denial of a request for a rate
 72.26 exception under section 256B.4914; or

72.27 (14) a person issued a notice of service termination under section 245A.11, subdivision
 72.28 11, that is not otherwise subject to appeal under subdivision 4a.

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

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

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

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

73.16 (e) The scope of hearings under paragraph (a), ~~clause~~ clauses (12) and (14), shall be
73.17 limited to whether the proposed termination of services is authorized under section 245D.10,
73.18 subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements
73.19 of section 245D.10, subdivision 3a, ~~paragraph~~ paragraphs (c) to (e), or 245A.11, subdivision
73.20 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of
73.21 termination of services, the scope of the hearing shall also include whether the case
73.22 management provider has finalized arrangements for a residential facility, a program, or
73.23 services that will meet the assessed needs of the recipient by the effective date of the service
73.24 termination.

73.25 (f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor
73.26 under contract with a county agency to provide social services is not a party and may not
73.27 request a hearing under this section, except if assisting a recipient as provided in subdivision
73.28 4.

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

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

74.1 (i) Unless federal or Minnesota law specifies a different time frame in which to file an
 74.2 appeal, an individual or organization specified in this section may contest the specified
 74.3 action, decision, or final disposition before the state agency by submitting a written request
 74.4 for a hearing to the state agency within 30 days after receiving written notice of the action,
 74.5 decision, or final disposition, or within 90 days of such written notice if the applicant,
 74.6 recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision
 74.7 13, why the request was not submitted within the 30-day time limit. The individual filing
 74.8 the appeal has the burden of proving good cause by a preponderance of the evidence.

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

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

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

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

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

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

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

74.26 (e) "Individual with a disability" means:

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

74.30 (2) an individual who meets a category of eligibility under section 256D.05, subdivision
 74.31 1, paragraph (a), clauses (1), (3), (5) to (9), or (14).

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

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

75.5 (1) is 18 years of age or older;

75.6 (2) is enrolled in medical assistance;

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

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

75.11 (5) has housing instability evidenced by:

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

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

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

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

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

75.21 (1) an assessor according to the criteria established in section 256B.0911, subdivision
 75.22 3a, using a format established by the commissioner;

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

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

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

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

76.1 (b) Housing transition services are defined as:

76.2 (1) tenant screening and housing assessment;

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

76.4 (3) identifying resources to cover onetime moving expenses;

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

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

76.7 (6) developing a housing support crisis plan.

76.8 (c) Housing and tenancy sustaining services include:

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

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

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

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

76.17 (5) assistance with housing recertification process;

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

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

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

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

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

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

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

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

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

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

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

77.18 Sec. 11. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

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

77.28 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
77.29 assessors to conduct the assessment. For a person with complex health care needs, a public
77.30 health or registered nurse from the team must be consulted.

77.31 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
77.32 be used to complete a comprehensive, person-centered assessment. The assessment must
77.33 include the health, psychological, functional, environmental, and social needs of the

78.1 individual necessary to develop a community support plan that meets the individual's needs
78.2 and preferences.

78.3 (d) The assessment must be conducted in a face-to-face interview with the person being
78.4 assessed and the person's legal representative. At the request of the person, other individuals
78.5 may participate in the assessment to provide information on the needs, strengths, and
78.6 preferences of the person necessary to develop a community support plan that ensures the
78.7 person's health and safety. Except for legal representatives or family members invited by
78.8 the person, persons participating in the assessment may not be a provider of service or have
78.9 any financial interest in the provision of services. For persons who are to be assessed for
78.10 elderly waiver customized living services under section 256B.0915, with the permission of
78.11 the person being assessed or the person's designated or legal representative, the client's
78.12 current or proposed provider of services may submit a copy of the provider's nursing
78.13 assessment or written report outlining its recommendations regarding the client's care needs.
78.14 The person conducting the assessment must notify the provider of the date by which this
78.15 information is to be submitted. This information shall be provided to the person conducting
78.16 the assessment prior to the assessment. For a person who is to be assessed for waiver services
78.17 under section 256B.092 or 256B.49, with the permission of the person being assessed or
78.18 the person's designated legal representative, the person's current provider of services may
78.19 submit a written report outlining recommendations regarding the person's care needs prepared
78.20 by a direct service employee with at least 20 hours of service to that client. The person
78.21 conducting the assessment or reassessment must notify the provider of the date by which
78.22 this information is to be submitted. This information shall be provided to the person
78.23 conducting the assessment and the person or the person's legal representative, and must be
78.24 considered prior to the finalization of the assessment or reassessment.

78.25 (e) The person or the person's legal representative must be provided with a written
78.26 community support plan within 40 calendar days of the assessment visit, regardless of
78.27 whether the individual is eligible for Minnesota health care programs. The written community
78.28 support plan must include:

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

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

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

78.34 (4) referral information; and

79.1 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

79.30 (4) the role of long-term care consultation assessment and support planning in eligibility
79.31 determination for waiver and alternative care programs, and state plan home care, case
79.32 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
79.33 and (b);

- 80.1 (5) information about Minnesota health care programs;
- 80.2 (6) the person's freedom to accept or reject the recommendations of the team;
- 80.3 (7) the person's right to confidentiality under the Minnesota Government Data Practices
80.4 Act, chapter 13;
- 80.5 (8) the certified assessor's decision regarding the person's need for institutional level of
80.6 care as determined under criteria established in subdivision 4e and the certified assessor's
80.7 decision regarding eligibility for all services and programs as defined in subdivision 1a,
80.8 paragraphs (a), clause (6), and (b); and
- 80.9 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
80.10 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
80.11 (8), and (b), and incorporating the decision regarding the need for institutional level of care
80.12 or the lead agency's final decisions regarding public programs eligibility according to section
80.13 256.045, subdivision 3.
- 80.14 (i) Face-to-face assessment completed as part of eligibility determination for the
80.15 alternative care, elderly waiver, community access for disability inclusion, community
80.16 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
80.17 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
80.18 the date of assessment.
- 80.19 (j) The effective eligibility start date for programs in paragraph (i) can never be prior to
80.20 the date of assessment. If an assessment was completed more than 60 days before the
80.21 effective waiver or alternative care program eligibility start date, assessment and support
80.22 plan information must be updated and documented in the department's Medicaid Management
80.23 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
80.24 state plan services, the effective date of eligibility for programs included in paragraph (i)
80.25 cannot be prior to the date the most recent updated assessment is completed.
- 80.26 (k) At the time of reassessment, the certified assessor shall assess each person receiving
80.27 waiver services currently residing in a community residential setting, or licensed adult foster
80.28 care home that is not the primary residence of the license holder, or in which the license
80.29 holder is not the primary caregiver, to determine if that person would prefer to be served in
80.30 a community-living settings as defined in section 256B.49, subdivision 23. The certified
80.31 assessor shall offer the person, through a person-centered planning process, the option to
80.32 receive alternative housing and service options.

81.1 Sec. 12. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

- 82.20 (1) promote the support of persons with disabilities in the most integrated settings;
 82.21 (2) expand the availability of services for persons who are eligible for medical assistance;
 82.22 (3) promote cost-effective options to institutional care; and
 82.23 (4) obtain federal financial participation.

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

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

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

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

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

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

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

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

83.16 Subd. 15. **Coordinated service and support plan; comprehensive transitional service**
 83.17 **plan; maintenance service plan.** (a) Each recipient of home and community-based waived
 83.18 services shall be provided a copy of the written coordinated service and support plan which
 83.19 meets the requirements in section 256B.092, subdivision 1b.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

86.33 (1) target counties and geographic areas which have:

- 87.1 (i) need for other types of services;
- 87.2 (ii) need for specialized services;
- 87.3 (iii) higher than average per capita use of licensed corporate foster care or community
- 87.4 residential settings; or
- 87.5 (iv) residents not living in the geographic area of their choice;
- 87.6 (2) demonstrate savings of medical assistance expenditures; and
- 87.7 (3) demonstrate that alternative services are based on the recipient's choice of provider
- 87.8 and are consistent with federal law, state law, and federally approved waiver plans.
- 87.9 The commissioner shall also consider any information provided by people using services,
- 87.10 their legal representatives, family members, or the lead agency on the impact of the planned
- 87.11 closure on people and the services they need.
- 87.12 (c) For each closure plan approved by the commissioner, a contract must be established
- 87.13 between the commissioner, the counties of financial responsibility, and the participating
- 87.14 license holder.

87.15 Sec. 19. Minnesota Statutes 2016, section 256D.44, subdivision 4, as amended by Laws

87.16 2017, chapter 59, section 12, is amended to read:

87.17 Subd. 4. **Temporary absence due to illness.** For the purposes of this subdivision, "home"

87.18 means a residence owned or rented by a recipient or the recipient's spouse. ~~Home does not~~

87.19 ~~include a group residential housing facility.~~ Assistance payments for recipients who are

87.20 temporarily absent from their home due to hospitalization for illness must continue at the

87.21 same level of payment during their absence if the following criteria are met:

- 87.22 (1) a physician, advanced practice registered nurse, or physician assistant certifies that
- 87.23 the absence is not expected to continue for more than three months;
- 87.24 (2) a physician, advanced practice registered nurse, or physician assistant certifies that
- 87.25 the recipient will be able to return to independent living; and
- 87.26 (3) the recipient has expenses associated with maintaining a residence in the community.

88.1 Sec. 20. Minnesota Statutes 2016, section 256D.44, subdivision 5, as amended by Laws
88.2 2017, chapter 40, article 1, section 84, and Laws 2017, chapter 59, section 13, is amended
88.3 to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

89.24 (i) relocating from an institution, a setting authorized to receive housing support under
89.25 chapter 256I, or an adult mental health residential treatment program under section
89.26 256B.0622; ~~or~~

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

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

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

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

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

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

90.13 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
 90.14 services provided to ~~residents of group residential housing providers~~ individuals in addition
 90.15 to room and board including, but not limited to, oversight and up to 24-hour supervision,
 90.16 medication reminders, assistance with transportation, arranging for meetings and
 90.17 appointments, and arranging for medical and social services.

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

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

90.24 (a) The individual is aged, blind, or is over 18 years of age and disabled as determined
 90.25 under the criteria used by the title II program of the Social Security Act, and meets the
 90.26 resource restrictions and standards of section 256P.02, and the individual's countable income
 90.27 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
 90.28 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
 90.29 income actually made available to a community spouse by an elderly waiver participant
 90.30 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,
 90.31 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
 90.32 provider of ~~group residential~~ housing support in which the individual resides.

91.1 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
 91.2 paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and the
 91.3 individual's resources are less than the standards specified by section 256P.02, and the
 91.4 individual's countable income as determined under section 256P.06, less the medical
 91.5 assistance personal needs allowance under section 256B.35 is less than the monthly rate
 91.6 specified in the agency's agreement with the provider of ~~group residential~~ housing support
 91.7 in which the individual resides.

91.8 (c) The individual receives licensed residential crisis stabilization services under section
 91.9 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive
 91.10 concurrent housing support payments if receiving licensed residential crisis stabilization
 91.11 services under section 256B.0624, subdivision 7.

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

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

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

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

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

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

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

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

92.6 Subd. 3. **Moratorium on development of ~~group residential~~ housing support beds.**

92.7 (a) Agencies shall not enter into agreements for new ~~group residential~~ housing support beds
 92.8 with total rates in excess of the MSA equivalent rate except:

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

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

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

93.1 demonstration project site who no longer participates in the demonstration program shall
93.2 retain eligibility for a ~~group residential~~ housing support payment in an amount determined
93.3 under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under
93.4 section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are
93.5 available and the services can be provided through a managed care entity. If federal matching
93.6 funds are not available, then service funding will continue under section 256I.05, subdivision
93.7 1a;

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

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

93.16 (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent
93.17 persons, operated by a ~~group residential~~ housing support provider that currently operates a
93.18 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

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

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

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

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

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

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

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

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

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

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

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

95.14 (c) The room and board rates will be increased each year when the MSA equivalent rate
95.15 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
95.16 the amount of the increase in the medical assistance personal needs allowance under section
95.17 256B.35.

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

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

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

96.1 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
96.2 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
96.3 9549.0058.

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

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

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

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

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

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

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

96.23 (2) operates a 62-bed facility; and

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

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

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

97.2 Subd. 1j. **Supplementary rate for certain facilities; Crow Wing County.**

97.3 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county
 97.4 agency shall negotiate a supplementary rate in addition to the rate specified in subdivision
 97.5 1, not to exceed \$700 per month, including any legislatively authorized inflationary
 97.6 adjustments, for a new 65-bed facility in Crow Wing County that will serve chemically
 97.7 dependent persons operated by a ~~group residential~~ housing support provider that currently
 97.8 operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in
 97.9 January of 2006.

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

97.11 Subd. 1m. **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.**

97.12 ~~(a)~~ Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
 97.13 shall negotiate a supplemental service rate in addition to the rate specified in subdivision
 97.14 1, not to exceed ~~\$700 per month~~ the maximum rate in subdivision 1a or the existing monthly
 97.15 rate, whichever is higher, including any legislatively authorized inflationary adjustments,
 97.16 for a ~~group residential~~ housing support provider that operates two ten-bed facilities, one
 97.17 located in Hennepin County and one located in Ramsey County, which provide community
 97.18 support and serve the mental health needs of individuals who have chronically lived
 97.19 unsheltered, providing 24-hour-per-day supervision.

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

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

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

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

- 98.1 (2) operates a 35-bed facility;
- 98.2 (3) serves women who are chemically dependent, mentally ill, or both;
- 98.3 (4) provides 24-hour per day supervision;
- 98.4 (5) provides on-site support with skilled professionals, including a licensed practical
- 98.5 nurse, registered nurses, peer specialists, and resident counselors; and
- 98.6 (6) provides independent living skills training and assistance with family reunification.

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

98.8 to read:

98.9 Subd. 1q. **Supplemental rate; Olmsted County.** Notwithstanding the provisions of

98.10 subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a

98.11 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$750 per

98.12 month, including any legislatively authorized inflationary adjustments, for a housing support

98.13 provider located in Olmsted County that operates long-term residential facilities with a total

98.14 of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day

98.15 supervision and other support services.

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

98.17 to read:

98.18 Subd. 1r. **Supplemental rate; Anoka County.** Notwithstanding the provisions in this

98.19 section, a county agency shall negotiate a supplemental rate for 42 beds in addition to the

98.20 rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision

98.21 1a, including any legislatively authorized inflationary adjustments, for a housing support

98.22 provider that is located in Anoka County and provides emergency housing on the former

98.23 Anoka Regional Treatment Center campus.

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

98.25 to read:

98.26 Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a

98.27 cost-neutral transfer of funding from the housing support fund to county human service

98.28 agencies for emergency shelter beds removed from the housing support census under a

98.29 biennial plan submitted by the county and approved by the commissioner. The plan must

98.30 describe: (1) anticipated and actual outcomes for persons experiencing homelessness in

98.31 emergency shelters; (2) improved efficiencies in administration; (3) requirements for

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

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

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

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

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

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

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

99.22 Subd. 8. **Amount of ~~group residential~~ housing support payment.** (a) The amount of
 99.23 a ~~group residential housing~~ room and board payment to be made on behalf of an eligible
 99.24 individual is determined by subtracting the individual's countable income under section
 99.25 256I.04, subdivision 1, for a whole calendar month from the ~~group residential housing~~
 99.26 ~~charge~~ room and board rate for that same month. The ~~group residential~~ housing charge
 99.27 support payment is determined by multiplying the ~~group residential~~ housing support rate
 99.28 times the period of time the individual was a resident or temporarily absent under section
 99.29 256I.05, subdivision 1c, paragraph (d).

99.30 (b) For an individual with earned income under paragraph (a), prospective budgeting
 99.31 must be used to determine the amount of the individual's payment for the following six-month
 99.32 period. An increase in income shall not affect an individual's eligibility or payment amount

100.1 until the month following the reporting month. A decrease in income shall be effective the
100.2 first day of the month after the month in which the decrease is reported.

100.3 (c) For an individual who receives licensed residential crisis stabilization services under
100.4 section 256B.0624, subdivision 7, the amount of housing support payment is determined
100.5 by multiplying the housing support rate times the period of time the individual was a resident.

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

100.7 **Sec. 37. [256L.09] COMMUNITY LIVING INFRASTRUCTURE.**

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

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

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

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

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

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

101.8	<u>Column A</u>	<u>Column B</u>	<u>Column C</u>
101.9	<u>144A.071, subdivision 4d</u>	<u>group residential housing</u>	<u>housing support under chapter</u> 101.10 <u>256I</u>
101.11	<u>201.061, subdivision 3</u>	<u>group residential housing</u>	<u>setting authorized to provide</u> 101.12 <u>housing support</u>
101.13	<u>244.052, subdivision 4c</u>	<u>group residential housing</u> 101.14 <u>facility</u>	<u>licensed setting authorized to</u> 101.15 <u>provide housing support</u> <u>under section 256I.04</u>
101.16	<u>245.466, subdivision 7</u>	<u>under group residential</u> 101.17 <u>housing</u>	<u>by housing support under</u> <u>chapter 256I</u>
101.18	<u>245.466, subdivision 7</u>	<u>from group residential housing</u>	<u>from housing support</u>
101.19	<u>245.4661, subdivision 6</u>	<u>group residential housing</u>	<u>housing support under chapter</u> 101.20 <u>256I</u>
101.21	<u>245C.10, subdivision 11</u>	<u>group residential housing or</u> 101.22 <u>supplementary services</u>	<u>housing support</u>
101.23	<u>256.01, subdivision 18</u>	<u>group residential housing</u>	<u>housing support under chapter</u> 101.24 <u>256I</u>
101.25	<u>256.017, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
101.26	<u>256.98, subdivision 8</u>	<u>group residential housing</u>	<u>housing support under chapter</u> 101.27 <u>256I</u>
101.28	<u>256B.49, subdivision 15</u>	<u>group residential housing</u>	<u>housing support under chapter</u> 101.29 <u>256I</u>
101.30	<u>256B.4914, subdivision 10</u>	<u>group residential housing rate</u> 101.31 <u>3 costs</u>	<u>housing support rate 3 costs</u> <u>under chapter 256I</u>
101.32	<u>256B.501, subdivision 4b</u>	<u>group residential housing</u>	<u>housing support</u>
101.33	<u>256B.77, subdivision 12</u>	<u>residential services covered</u> 101.34 <u>under the group residential</u> 101.35 <u>housing program</u>	<u>housing support services</u> <u>under chapter 256I</u>
101.36	<u>256D.44, subdivision 2</u>	<u>group residential housing</u> 101.37 <u>facility</u>	<u>setting authorized to provide</u> <u>housing support</u>
101.38	<u>256G.01, subdivision 3</u>	<u>group residential housing</u>	<u>housing support under chapter</u> 101.39 <u>256I</u>
101.40	<u>256I.01</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
101.41	<u>256I.02</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
101.42	<u>256I.03, subdivision 2</u>	<u>"Group residential housing"</u>	<u>"Room and board"</u>

102.1	<u>256I.03, subdivision 2</u>	<u>Group residential housing</u>	<u>The room and board</u>
102.2	<u>256I.03, subdivision 3</u>	<u>"Group residential housing"</u>	<u>"Housing support"</u>
102.3	<u>256I.03, subdivision 6</u>	<u>group residential housing</u>	<u>room and board</u>
102.4	<u>256I.03, subdivisions 7 and 9</u>	<u>group residential housing</u>	<u>housing support</u>
102.5	<u>256I.04, subdivisions 1a, 1b,</u>	<u>group residential housing</u>	<u>housing support</u>
102.6	<u>1c, and 2</u>		
102.7	<u>256I.04, subdivision 2a</u>	<u>provide group residential</u>	<u>provide housing support</u>
102.8		<u>housing</u>	
102.9	<u>256I.04, subdivision 2a</u>	<u>of group residential housing</u>	<u>of housing support</u>
102.10		<u>or supplementary services</u>	
102.11	<u>256I.04, subdivision 2a</u>	<u>complete group residential</u>	<u>complete housing support</u>
102.12		<u>housing</u>	
102.13	<u>256I.04, subdivision 2b</u>	<u>group residential housing or</u>	<u>housing support</u>
102.14		<u>supplementary services</u>	
102.15	<u>256I.04, subdivision 2b</u>	<u>provision of group residential</u>	<u>provision of housing support</u>
102.16		<u>housing</u>	
102.17	<u>256I.04, subdivision 2c</u>	<u>group residential housing or</u>	<u>housing support</u>
102.18		<u>supplementary services</u>	
102.19	<u>256I.04, subdivision 2e</u>	<u>group residential housing or</u>	<u>housing support</u>
102.20		<u>supplementary services</u>	
102.21	<u>256I.04, subdivision 4</u>	<u>group residential housing</u>	<u>room and board rate</u>
102.22		<u>payment for room and board</u>	
102.23	<u>256I.05, subdivision 1</u>	<u>living in group residential</u>	<u>receiving housing support</u>
102.24		<u>housing</u>	
102.25	<u>256I.05, subdivisions 1h, 1k,</u>	<u>group residential housing</u>	<u>housing support</u>
102.26	<u>1l, 7b, and 7c</u>		
102.27	<u>256I.05, subdivision 2</u>	<u>group residential housing</u>	<u>room and board</u>
102.28	<u>256I.05, subdivision 3</u>	<u>group residential housing</u>	<u>room and board</u>
102.29	<u>256I.05, subdivision 6</u>	<u>reside in group residential</u>	<u>receive housing support</u>
102.30		<u>housing</u>	
102.31	<u>256I.06, subdivisions 1, 3, 4,</u>	<u>group residential housing</u>	<u>housing support</u>
102.32	<u>and 6</u>		
102.33	<u>256I.06, subdivision 7</u>	<u>group residential housing</u>	<u>the housing support</u>
102.34	<u>256I.08</u>	<u>group residential housing</u>	<u>housing support</u>
102.35	<u>256P.03, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
102.36	<u>256P.05, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
102.37	<u>256P.07, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
102.38	<u>256P.08, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
102.39	<u>290A.03, subdivision 8</u>	<u>accepts group residential</u>	<u>accepts housing support</u>
102.40		<u>housing</u>	
102.41	<u>290A.03, subdivision 8</u>	<u>the group residential housing</u>	<u>the housing support program</u>
102.42		<u>program</u>	

103.1 **ARTICLE 3**103.2 **CONTINUING CARE**

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

103.4 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
103.5 submit to the commissioner of health MDS assessments that conform with the assessment
103.6 schedule defined by Code of Federal Regulations, title 42, section 483.20, and published
103.7 by the United States Department of Health and Human Services, Centers for Medicare and
103.8 Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version
103.9 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.
103.10 The commissioner of health may substitute successor manuals or question and answer
103.11 documents published by the United States Department of Health and Human Services,
103.12 Centers for Medicare and Medicaid Services, to replace or supplement the current version
103.13 of the manual or document.

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

103.16 (1) a new admission assessment;

103.17 (2) an annual assessment which must have an assessment reference date (ARD) within
103.18 92 days of the previous assessment and the previous comprehensive assessment;

103.19 (3) a significant change in status assessment must be completed within 14 days of the
103.20 identification of a significant change, whether improvement or decline, and regardless of
103.21 the amount of time since the last significant change in status assessment;

103.22 (4) all quarterly assessments must have an assessment reference date (ARD) within 92
103.23 days of the ARD of the previous assessment;

103.24 (5) any significant correction to a prior comprehensive assessment, if the assessment
103.25 being corrected is the current one being used for RUG classification; and

103.26 (6) any significant correction to a prior quarterly assessment, if the assessment being
103.27 corrected is the current one being used for RUG classification.

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

103.30 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
103.31 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
103.32 Aging; and

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

104.5 Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:

104.6 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or
104.7 submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within
104.8 seven days of the time requirements listed in the Long-Term Care Facility Resident
104.9 Assessment Instrument User's Manual is subject to a reduced rate for that resident. The
104.10 reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the
104.11 day of admission for new admission assessments, on the ARD for significant change in
104.12 status assessments, or on the day that the assessment was due for all other assessments and
104.13 continues in effect until the first day of the month following the date of submission and
104.14 acceptance of the resident's assessment.

104.15 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
104.16 are equal to or greater than ~~1.0~~ 0.1 percent of the total operating costs on the facility's most
104.17 recent annual statistical and cost report, a facility may apply to the commissioner of human
104.18 services for a reduction in the total penalty amount. The commissioner of human services,
104.19 in consultation with the commissioner of health, may, at the sole discretion of the
104.20 commissioner of human services, limit the penalty for residents covered by medical assistance
104.21 to ~~15~~ ten days.

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

104.23 Sec. 3. Minnesota Statutes 2016, section 144.562, subdivision 2, is amended to read:

104.24 Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a
104.25 license condition for swing beds unless (1) it either has a licensed bed capacity of less than
104.26 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42,
104.27 section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that
104.28 were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed
104.29 capacity of less than 65 beds and the available nursing homes within 50 miles have had, in
104.30 the aggregate, an average occupancy rate of 96 percent or higher in the most recent two
104.31 years as documented on the statistical reports to the Department of Health; and (2) it is
104.32 located in a rural area as defined in the federal Medicare regulations, Code of Federal
104.33 Regulations, title 42, section 482.66.

105.1 (b) Except for those critical access hospitals established under section 144.1483, clause
105.2 (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section
105.3 1395i-4, that have an attached nursing home or that owned a nursing home located in the
105.4 same municipality as of May 1, 2005, eligible hospitals are allowed a total of 2,000 days
105.5 of swing bed use per year. Critical access hospitals that have an attached nursing home or
105.6 that owned a nursing home located in the same municipality as of May 1, 2005, are allowed
105.7 swing bed use as provided in federal law.

105.8 (c) Except for critical access hospitals that have an attached nursing home or that owned
105.9 a nursing home located in the same municipality as of May 1, 2005, the commissioner of
105.10 health may approve swing bed use beyond 2,000 days as long as there are no Medicare
105.11 certified skilled nursing facility beds available within 25 miles of that hospital that are
105.12 willing to admit the patient and the patient agrees to the referral being sent to the skilled
105.13 nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain
105.14 documentation that they have contacted skilled nursing facilities within 25 miles to determine
105.15 if any skilled nursing facility beds are available that are willing to admit the patient and the
105.16 patient agrees to the referral being sent to the skilled nursing facility.

105.17 (d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which
105.18 this limit applies may admit six additional patients to swing beds each year without seeking
105.19 approval from the commissioner or being in violation of this subdivision. These six swing
105.20 bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals
105.21 subject to this limit.

105.22 (e) A health care system that is in full compliance with this subdivision may allocate its
105.23 total limit of swing bed days among the hospitals within the system, provided that no hospital
105.24 in the system without an attached nursing home may exceed 2,000 swing bed days per year.

105.25 Sec. 4. Minnesota Statutes 2016, section 144A.071, subdivision 4d, as amended by Laws
105.26 2017, chapter 40, article 1, section 25, is amended to read:

105.27 Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in
105.28 consultation with the commissioner of human services, may approve a request for
105.29 consolidation of nursing facilities which includes the closure of one or more facilities and
105.30 the upgrading of the physical plant of the remaining nursing facility or facilities, the costs
105.31 of which exceed the threshold project limit under subdivision 2, clause (a). The
105.32 commissioners shall consider the criteria in this section, section 144A.073, and section
105.33 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners

106.1 approve the request, the commissioner of human services shall calculate an external fixed
106.2 costs rate adjustment according to clauses (1) to (3):

106.3 (1) the closure of beds shall not be eligible for a planned closure rate adjustment under
106.4 section 256R.40, subdivision 5;

106.5 (2) the construction project permitted in this clause shall not be eligible for a threshold
106.6 project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception
106.7 adjustment under section 144A.073; and

106.8 (3) the payment rate for external fixed costs for a remaining facility or facilities shall
106.9 be increased by an amount equal to 65 percent of the projected net cost savings to the state
106.10 calculated in paragraph (b), divided by the state's medical assistance percentage of medical
106.11 assistance dollars, and then divided by estimated medical assistance resident days, as
106.12 determined in paragraph (c), of the remaining nursing facility or facilities in the request in
106.13 this paragraph. The rate adjustment is effective on the ~~later of the first day of the month~~
106.14 ~~following~~ first day of the month of January or July, whichever date occurs first following
106.15 both the completion of the construction upgrades in the consolidation plan or the first day
106.16 of the month following and the complete closure of a facility closure of the facility or
106.17 facilities designated for closure in the consolidation plan. If more than one facility is receiving
106.18 upgrades in the consolidation plan, each facility's date of construction completion must be
106.19 evaluated separately.

106.20 (b) For purposes of calculating the net cost savings to the state, the commissioner shall
106.21 consider clauses (1) to (7):

106.22 (1) the annual savings from estimated medical assistance payments from the net number
106.23 of beds closed taking into consideration only beds that are in active service on the date of
106.24 the request and that have been in active service for at least three years;

106.25 (2) the estimated annual cost of increased case load of individuals receiving services
106.26 under the elderly waiver;

106.27 (3) the estimated annual cost of elderly waiver recipients receiving support under group
106.28 residential housing;

106.29 (4) the estimated annual cost of increased case load of individuals receiving services
106.30 under the alternative care program;

106.31 (5) the annual loss of license surcharge payments on closed beds;

106.32 (6) the savings from not paying planned closure rate adjustments that the facilities would
106.33 otherwise be eligible for under section 256R.40; and

107.1 (7) the savings from not paying external fixed costs payment rate adjustments from
107.2 submission of renovation costs that would otherwise be eligible as threshold projects under
107.3 section 256B.434, subdivision 4f.

107.4 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
107.5 assistance resident days of the remaining facility or facilities shall be computed assuming
107.6 95 percent occupancy multiplied by the historical percentage of medical assistance resident
107.7 days of the remaining facility or facilities, as reported on the facility's or facilities' most
107.8 recent nursing facility statistical and cost report filed before the plan of closure is submitted,
107.9 multiplied by 365.

107.10 (d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy
107.11 percentages will be those reported on the facility's or facilities' most recent nursing facility
107.12 statistical and cost report filed before the plan of closure is submitted, and the average
107.13 payment rates shall be calculated based on the approved payment rates in effect at the time
107.14 the consolidation request is submitted.

107.15 (e) To qualify for the external fixed costs payment rate adjustment under this subdivision,
107.16 the closing facilities shall:

107.17 (1) submit an application for closure according to section 256R.40, subdivision 2; and

107.18 (2) follow the resident relocation provisions of section 144A.161.

107.19 (f) The county or counties in which a facility or facilities are closed under this subdivision
107.20 shall not be eligible for designation as a hardship area under subdivision 3 for five years
107.21 from the date of the approval of the proposed consolidation. The applicant shall notify the
107.22 county of this limitation and the county shall acknowledge this in a letter of support.

107.23 **EFFECTIVE DATE.** This section is effective for consolidations occurring after July
107.24 1, 2017.

107.25 Sec. 5. Minnesota Statutes 2016, section 144A.74, is amended to read:

107.26 **144A.74 MAXIMUM CHARGES.**

107.27 A supplemental nursing services agency must not bill or receive payments from a nursing
107.28 home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted
107.29 average wage rate, plus a factor determined by the commissioner to incorporate payroll
107.30 taxes as defined in Minnesota Rules, part 9549.0020, subpart 33 section 256R.02, subdivision
107.31 37, for the applicable employee classification for the geographic group ~~to which the nursing~~
107.32 ~~home is assigned under Minnesota Rules, part 9549.0052~~ specified in section 256R.23,

108.1 subdivision 4. The weighted average wage rates must be determined by the commissioner
108.2 of human services and reported to the commissioner of health on an annual basis. Wages
108.3 are defined as hourly rate of pay and shift differential, including weekend shift differential
108.4 and overtime. Facilities shall provide information necessary to determine weighted average
108.5 wage rates to the commissioner of human services in a format requested by the commissioner.
108.6 The maximum rate must include all charges for administrative fees, contract fees, or other
108.7 special charges in addition to the hourly rates for the temporary nursing pool personnel
108.8 supplied to a nursing home. A nursing home that pays for the actual travel and housing costs
108.9 for supplemental nursing services agency staff working at the facility and that pays these
108.10 costs to the employee, the agency, or another vendor, is not violating the limitation on
108.11 charges described in this section.

108.12 **EFFECTIVE DATE.** This section is effective January 1, 2018.

108.13 Sec. 6. Minnesota Statutes 2016, section 256.975, subdivision 7, is amended to read:

108.14 Subd. 7. **Consumer information and assistance and long-term care options**
108.15 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
108.16 statewide service to aid older Minnesotans and their families in making informed choices
108.17 about long-term care options and health care benefits. Language services to persons with
108.18 limited English language skills may be made available. The service, known as Senior
108.19 LinkAge Line, shall serve older adults as the designated Aging and Disability Resource
108.20 Center under United States Code, title 42, section 3001, the Older Americans Act
108.21 Amendments of 2006 in partnership with the Disability Linkage Line under section 256.01,
108.22 subdivision 24, and must be available during business hours through a statewide toll-free
108.23 number and the Internet. The Minnesota Board on Aging shall consult with, and when
108.24 appropriate work through, the area agencies on aging counties, and other entities that serve
108.25 aging and disabled populations of all ages, to provide and maintain the telephone
108.26 infrastructure and related support for the Aging and Disability Resource Center partners
108.27 which agree by memorandum to access the infrastructure, including the designated providers
108.28 of the Senior LinkAge Line and the Disability Linkage Line.

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

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

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

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

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

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

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

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

109.16 (8) link callers with quality profiles for nursing facilities and other home and
109.17 community-based services providers developed by the commissioners of health and human
109.18 services;

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

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

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

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

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

110.4 (10) incorporate information about the availability of housing options, as well as
110.5 registered housing with services and consumer rights within the MinnesotaHelp.info network
110.6 long-term care database to facilitate consumer comparison of services and costs among
110.7 housing with services establishments and with other in-home services and to support financial
110.8 self-sufficiency as long as possible. Housing with services establishments and their arranged
110.9 home care providers shall provide information that will facilitate price comparisons, including
110.10 delineation of charges for rent and for services available. The commissioners of health and
110.11 human services shall align the data elements required by section 144G.06, the Uniform
110.12 Consumer Information Guide, and this section to provide consumers standardized information
110.13 and ease of comparison of long-term care options. The commissioner of human services
110.14 shall provide the data to the Minnesota Board on Aging for inclusion in the
110.15 MinnesotaHelp.info network long-term care database;

110.16 (11) provide long-term care options counseling. Long-term care options counselors shall:

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

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

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

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

110.32 (12) using risk management and support planning protocols, provide long-term care
110.33 options counseling under clause (13) to current residents of nursing homes deemed
110.34 appropriate for discharge by the commissioner, ~~former residents of nursing homes who~~

111.1 ~~were discharged to community settings, and older adults who request service after~~
111.2 ~~consultation with the Senior LinkAge Line under clause (13). The Senior LinkAge Line~~
111.3 ~~shall also receive referrals from the residents or staff of nursing homes. who meet a profile~~
111.4 ~~that demonstrates that the consumer is either at risk of readmission to a nursing home or~~
111.5 ~~hospital, or would benefit from long-term care options counseling to age in place. The Senior~~
111.6 ~~LinkAge Line shall identify and contact residents or patients deemed appropriate ~~for~~~~
111.7 ~~discharge by developing targeting criteria and creating a profile in consultation with the~~
111.8 ~~commissioner ~~who~~. The commissioner shall provide designated Senior LinkAge Line contact~~
111.9 ~~centers with a list of current or former nursing home residents or people discharged from a~~
111.10 ~~hospital or for whom Medicare home care has ended, that meet the criteria as being~~
111.11 ~~appropriate for ~~discharge planning~~ long-term care options counseling through a referral via~~
111.12 ~~a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a~~
111.13 ~~preference to receive long-term care options counseling, with initial assessment and, if~~
111.14 ~~appropriate, a referral to:~~

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

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

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

111.20 (13) develop referral protocols and processes that will assist certified health care homes,
111.21 Medicare home care, and hospitals to identify at-risk older adults and determine when to
111.22 refer these individuals to the Senior LinkAge Line for long-term care options counseling
111.23 under this section. The commissioner is directed to work with the commissioner of health
111.24 to develop protocols that would comply with the health care home designation criteria and
111.25 protocols available at the time of hospital discharge or the end of Medicare home care. The
111.26 commissioner shall keep a record of the number of people who choose long-term care
111.27 options counseling as a result of this section.

111.28 (c) Nursing homes shall provide contact information to the Senior LinkAge Line for
111.29 residents identified in paragraph (b), clause (12), to provide long-term care options counseling
111.30 pursuant to paragraph (b), clause (11). The contact information for residents shall include
111.31 all information reasonably necessary to contact residents, including first and last names,
111.32 permanent and temporary addresses, telephone numbers, and e-mail addresses.

111.33 (d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer
111.34 who receives long-term care options counseling under paragraph (b), clause (12) or (13),

112.1 and who uses an unpaid caregiver to the self-directed caregiver service under subdivision
 112.2 12.

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

112.4 Sec. 7. Minnesota Statutes 2016, section 256.975, is amended by adding a subdivision to
 112.5 read:

112.6 Subd. 12. **Self-directed caregiver grants.** Beginning on July 1, 2019, the Minnesota
 112.7 Board on Aging shall administer self-directed caregiver grants to support at risk family
 112.8 caregivers of older adults or others eligible under the Older Americans Act of 1965, United
 112.9 States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in
 112.10 the caregivers' roles so older adults can remain at home longer. The board shall give priority
 112.11 to consumers referred under section 256.975, subdivision 7, paragraph (d).

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

112.13 Sec. 8. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

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

112.23 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
 112.24 assessors to conduct the assessment. For a person with complex health care needs, a public
 112.25 health or registered nurse from the team must be consulted.

112.26 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
 112.27 be used to complete a comprehensive, person-centered assessment. The assessment must
 112.28 include the health, psychological, functional, environmental, and social needs of the
 112.29 individual necessary to develop a community support plan that meets the individual's needs
 112.30 and preferences.

112.31 (d) The assessment must be conducted in a face-to-face interview with the person being
 112.32 assessed and the person's legal representative. At the request of the person, other individuals

113.1 may participate in the assessment to provide information on the needs, strengths, and
113.2 preferences of the person necessary to develop a community support plan that ensures the
113.3 person's health and safety. Except for legal representatives or family members invited by
113.4 the person, persons participating in the assessment may not be a provider of service or have
113.5 any financial interest in the provision of services. For persons who are to be assessed for
113.6 elderly waiver customized living or adult day services under section 256B.0915, with the
113.7 permission of the person being assessed or the person's designated or legal representative,
113.8 the client's current or proposed provider of services may submit a copy of the provider's
113.9 nursing assessment or written report outlining its recommendations regarding the client's
113.10 care needs. The person conducting the assessment must notify the provider of the date by
113.11 which this information is to be submitted. This information shall be provided to the person
113.12 conducting the assessment prior to the assessment. For a person who is to be assessed for
113.13 waiver services under section 256B.092 or 256B.49, with the permission of the person being
113.14 assessed or the person's designated legal representative, the person's current provider of
113.15 services may submit a written report outlining recommendations regarding the person's care
113.16 needs prepared by a direct service employee with at least 20 hours of service to that client.
113.17 The person conducting the assessment or reassessment must notify the provider of the date
113.18 by which this information is to be submitted. This information shall be provided to the
113.19 person conducting the assessment and the person or the person's legal representative, and
113.20 must be considered prior to the finalization of the assessment or reassessment.

113.21 (e) The person or the person's legal representative must be provided with a written
113.22 community support plan within 40 calendar days of the assessment visit, regardless of
113.23 whether the individual is eligible for Minnesota health care programs.

113.24 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
113.25 provider who submitted information under paragraph (d) shall receive the final written
113.26 community support plan when available and the Residential Services Workbook.

113.27 (g) The written community support plan must include:

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

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

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

113.33 (4) referral information; and

114.1 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

114.30 (4) the role of long-term care consultation assessment and support planning in eligibility
114.31 determination for waiver and alternative care programs, and state plan home care, case
114.32 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
114.33 and (b);

- 115.1 (5) information about Minnesota health care programs;
- 115.2 (6) the person's freedom to accept or reject the recommendations of the team;
- 115.3 (7) the person's right to confidentiality under the Minnesota Government Data Practices
115.4 Act, chapter 13;
- 115.5 (8) the certified assessor's decision regarding the person's need for institutional level of
115.6 care as determined under criteria established in subdivision 4e and the certified assessor's
115.7 decision regarding eligibility for all services and programs as defined in subdivision 1a,
115.8 paragraphs (a), clause (6), and (b); and

- 115.9 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
115.10 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
115.11 (8), and (b), and incorporating the decision regarding the need for institutional level of care
115.12 or the lead agency's final decisions regarding public programs eligibility according to section
115.13 256.045, subdivision 3.

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

115.19 ~~(j)~~ (l) The effective eligibility start date for programs in paragraph ~~(j)~~(k) can never be
115.20 prior to the date of assessment. If an assessment was completed more than 60 days before
115.21 the effective waiver or alternative care program eligibility start date, assessment and support
115.22 plan information must be updated and documented in the department's Medicaid Management
115.23 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
115.24 state plan services, the effective date of eligibility for programs included in paragraph ~~(j)~~
115.25 (k) cannot be prior to the date the most recent updated assessment is completed.

115.26 (m) If an eligibility update is completed within 90 days of the previous face-to-face
115.27 assessment and documented in the department's Medicaid Management Information System
115.28 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
115.29 of the previous face-to-face assessment when all other eligibility requirements are met.

115.30 Sec. 9. Minnesota Statutes 2016, section 256B.0915, subdivision 3a, is amended to read:

115.31 Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal
115.32 year in which the resident assessment system as described in section ~~256B.438~~ 256R.17 for
115.33 nursing home rate determination is implemented and the first day of each subsequent state

116.1 fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver
116.2 client shall be the monthly limit of the case mix resident class to which the waiver client
116.3 would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the
116.4 last day of the previous state fiscal year, adjusted by any legislatively adopted home and
116.5 community-based services percentage rate adjustment. If a legislatively authorized increase
116.6 is service-specific, the monthly cost limit shall be adjusted based on the overall average
116.7 increase to the elderly waiver program.

116.8 (b) The monthly limit for the cost of waived services under paragraph (a) to an
116.9 individual elderly waiver client assigned to a case mix classification A with:

116.10 (1) no dependencies in activities of daily living; or

116.11 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating when
116.12 the dependency score in eating is three or greater as determined by an assessment performed
116.13 under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new
116.14 participants enrolled in the program on or after July 1, 2011. This monthly limit shall be
116.15 applied to all other participants who meet this criteria at reassessment. This monthly limit
116.16 shall be increased annually as described in paragraphs (a) and (e).

116.17 (c) If extended medical supplies and equipment or environmental modifications are or
116.18 will be purchased for an elderly waiver client, the costs may be prorated for up to 12
116.19 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's
116.20 waived services exceeds the monthly limit established in paragraph (a), (b), (d), or (e),
116.21 the annual cost of all waived services shall be determined. In this event, the annual cost
116.22 of all waived services shall not exceed 12 times the monthly limit of waived services
116.23 as described in paragraph (a), (b), (d), or (e).

116.24 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including any
116.25 necessary home care services described in section 256B.0651, subdivision 2, for individuals
116.26 who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1,
116.27 paragraph (g), shall be the average of the monthly medical assistance amount established
116.28 for home care services as described in section 256B.0652, subdivision 7, and the annual
116.29 average contracted amount established by the commissioner for nursing facility services
116.30 for ventilator-dependent individuals. This monthly limit shall be increased annually as
116.31 described in paragraphs (a) and (e).

116.32 (e) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, the monthly
116.33 cost limits for elderly waiver services in effect on the previous ~~June 30~~ December 31 shall
116.34 be increased by the difference between any legislatively adopted home and community-based

117.1 provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and
 117.2 the average statewide percentage increase in nursing facility operating payment rates under
 117.3 ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January
 117.4 1. This paragraph shall only apply if the average statewide percentage increase in nursing
 117.5 facility operating payment rates is greater than any legislatively adopted home and
 117.6 community-based provider rate increases effective on ~~July~~ January 1, or occurring since
 117.7 the previous ~~July~~ January 1.

117.8 Sec. 10. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

117.9 Subd. 3e. **Customized living service rate.** (a) Payment for customized living services
 117.10 shall be a monthly rate authorized by the lead agency within the parameters established by
 117.11 the commissioner. The payment agreement must delineate the amount of each component
 117.12 service included in the recipient's customized living service plan. The lead agency, with
 117.13 input from the provider of customized living services, shall ensure that there is a documented
 117.14 need within the parameters established by the commissioner for all component customized
 117.15 living services authorized.

117.16 (b) The payment rate must be based on the amount of component services to be provided
 117.17 utilizing component rates established by the commissioner. Counties and tribes shall use
 117.18 tools issued by the commissioner to develop and document customized living service plans
 117.19 and rates.

117.20 (c) Component service rates must not exceed payment rates for comparable elderly
 117.21 waiver or medical assistance services and must reflect economies of scale. Customized
 117.22 living services must not include rent or raw food costs.

117.23 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
 117.24 individualized monthly authorized payment for the customized living service plan shall not
 117.25 exceed 50 percent of the ~~greater of either the statewide or any of the geographic groups'~~
 117.26 weighted average monthly nursing facility rate of the case mix resident class to which the
 117.27 elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051
 117.28 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph
 117.29 (a). ~~Effective On July 1 of the state fiscal~~ each year in which the resident assessment system
 117.30 ~~as described in section 256B.438 for nursing home rate determination is implemented and~~
 117.31 ~~July 1 of each subsequent state fiscal year~~, the individualized monthly authorized payment
 117.32 for the services described in this clause shall not exceed the limit which was in effect on
 117.33 June 30 of the previous state fiscal year updated annually based on legislatively adopted
 117.34 changes to all service rate maximums for home and community-based service providers.

118.1 (e) ~~Effective July 1, 2011,~~ The individualized monthly payment for the customized living
 118.2 service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly
 118.3 authorized payment limit for customized living for individuals classified as case mix A,
 118.4 reduced by 25 percent. This rate limit must be applied to all new participants enrolled in
 118.5 the program on or after July 1, 2011, who meet the criteria described in subdivision 3a,
 118.6 paragraph (b). This monthly limit also applies to all other participants who meet the criteria
 118.7 described in subdivision 3a, paragraph (b), at reassessment.

118.8 (f) Customized living services are delivered by a provider licensed by the Department
 118.9 of Health as a class A or class F home care provider and provided in a building that is
 118.10 registered as a housing with services establishment under chapter 144D. Licensed home
 118.11 care providers are subject to section 256B.0651, subdivision 14.

118.12 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
 118.13 family for additional units of any allowable component service beyond those available under
 118.14 the service rate limits described in paragraph ~~(d)~~ (e), nor for additional units of any allowable
 118.15 component service beyond those approved in the service plan by the lead agency.

118.16 (h) ~~Effective July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
 118.17 individualized service rate limits for customized living services under this subdivision shall
 118.18 be increased by the difference between any legislatively adopted home and community-based
 118.19 provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and
 118.20 the average statewide percentage increase in nursing facility operating payment rates under
 118.21 ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January
 118.22 1. This paragraph shall only apply if the average statewide percentage increase in nursing
 118.23 facility operating payment rates is greater than any legislatively adopted home and
 118.24 community-based provider rate increases effective on ~~July~~ January 1, or occurring since
 118.25 the previous ~~July~~ January 1.

118.26 **EFFECTIVE DATE.** This section prevails over any conflicting amendment regardless
 118.27 of the order of enactment.

118.28 Sec. 11. Minnesota Statutes 2016, section 256B.0915, subdivision 3h, is amended to read:

118.29 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment
 118.30 rate for 24-hour customized living services is a monthly rate authorized by the lead agency
 118.31 within the parameters established by the commissioner of human services. The payment
 118.32 agreement must delineate the amount of each component service included in each recipient's
 118.33 customized living service plan. The lead agency, with input from the provider of customized
 118.34 living services, shall ensure that there is a documented need within the parameters established

119.1 by the commissioner for all component customized living services authorized. The lead
119.2 agency shall not authorize 24-hour customized living services unless there is a documented
119.3 need for 24-hour supervision.

119.4 (b) For purposes of this section, "24-hour supervision" means that the recipient requires
119.5 assistance due to needs related to one or more of the following:

119.6 (1) intermittent assistance with toileting, positioning, or transferring;

119.7 (2) cognitive or behavioral issues;

119.8 (3) a medical condition that requires clinical monitoring; or

119.9 (4) for all new participants enrolled in the program on or after July 1, 2011, and all other
119.10 participants at their first reassessment after July 1, 2011, dependency in at least three of the
119.11 following activities of daily living as determined by assessment under section 256B.0911:
119.12 bathing; dressing; grooming; walking; or eating when the dependency score in eating is
119.13 three or greater; and needs medication management and at least 50 hours of service per
119.14 month. The lead agency shall ensure that the frequency and mode of supervision of the
119.15 recipient and the qualifications of staff providing supervision are described and meet the
119.16 needs of the recipient.

119.17 (c) The payment rate for 24-hour customized living services must be based on the amount
119.18 of component services to be provided utilizing component rates established by the
119.19 commissioner. Counties and tribes will use tools issued by the commissioner to develop
119.20 and document customized living plans and authorize rates.

119.21 (d) Component service rates must not exceed payment rates for comparable elderly
119.22 waiver or medical assistance services and must reflect economies of scale.

119.23 (e) The individually authorized 24-hour customized living payments, in combination
119.24 with the payment for other elderly waiver services, including case management, must not
119.25 exceed the recipient's community budget cap specified in subdivision 3a. Customized living
119.26 services must not include rent or raw food costs.

119.27 (f) The individually authorized 24-hour customized living payment rates shall not exceed
119.28 the 95 percentile of statewide monthly authorizations for 24-hour customized living services
119.29 in effect and in the Medicaid management information systems on March 31, 2009, for each
119.30 case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which
119.31 elderly waiver service clients are assigned. When there are fewer than 50 authorizations in
119.32 effect in the case mix resident class, the commissioner shall multiply the calculated service
119.33 payment rate maximum for the A classification by the standard weight for that classification

120.1 under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment
120.2 rate maximum. Service payment rate maximums shall be updated annually based on
120.3 legislatively adopted changes to all service rates for home and community-based service
120.4 providers.

120.5 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may
120.6 establish alternative payment rate systems for 24-hour customized living services in housing
120.7 with services establishments which are freestanding buildings with a capacity of 16 or fewer,
120.8 by applying a single hourly rate for covered component services provided in either:

120.9 (1) licensed corporate adult foster homes; or

120.10 (2) specialized dementia care units which meet the requirements of section 144D.065
120.11 and in which:

120.12 (i) each resident is offered the option of having their own apartment; or

120.13 (ii) the units are licensed as board and lodge establishments with maximum capacity of
120.14 eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
120.15 subparts 1, 2, 3, and 4, item A.

120.16 (h) Twenty-four-hour customized living services are delivered by a provider licensed
120.17 by the Department of Health as a class A or class F home care provider and provided in a
120.18 building that is registered as a housing with services establishment under chapter 144D.
120.19 Licensed home care providers are subject to section 256B.0651, subdivision 14.

120.20 (i) A provider may not bill or otherwise charge an elderly waiver participant or their
120.21 family for additional units of any allowable component service beyond those available under
120.22 the service rate limits described in paragraph (e), nor for additional units of any allowable
120.23 component service beyond those approved in the service plan by the lead agency.

120.24 (j) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
120.25 individualized service rate limits for 24-hour customized living services under this
120.26 subdivision shall be increased by the difference between any legislatively adopted home
120.27 and community-based provider rate increases effective on ~~July~~ January 1 or since the previous
120.28 ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating
120.29 payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective
120.30 the previous January 1. This paragraph shall only apply if the average statewide percentage
120.31 increase in nursing facility operating payment rates is greater than any legislatively adopted
120.32 home and community-based provider rate increases effective on ~~July~~ January 1, or occurring
120.33 since the previous ~~July~~ January 1.

121.1 Sec. 12. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

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

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

121.17 (c) The lead agency shall conduct a change-in-condition reassessment before the annual
121.18 reassessment in cases where a client's condition changed due to a major health event, an
121.19 emerging need or risk, worsening health condition, or cases where the current services do
121.20 not meet the client's needs. A change-in-condition reassessment may be initiated by the lead
121.21 agency, or it may be requested by the client or requested on the client's behalf by another
121.22 party, such as a provider of services. The lead agency shall complete a change-in-condition
121.23 reassessment no later than 20 calendar days from the request. The lead agency shall conduct
121.24 these assessments in a timely manner and expedite urgent requests. The lead agency shall
121.25 evaluate urgent requests based on the client's needs and risk to the client if a reassessment
121.26 is not completed.

121.27 Sec. 13. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
121.28 to read:

121.29 Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12
121.30 to 16 apply to elderly waiver and elderly waiver customized living under this section,
121.31 alternative care under section 256B.0913, essential community supports under section
121.32 256B.0922, and community access for disability inclusion customized living, brain injury
121.33 customized living, and elderly waiver foster care and residential care.

122.1 Sec. 14. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
122.2 to read:

122.3 Subd. 12. **Payment rates; phase-in.** Effective January 1, 2019, all rates and rate
122.4 components for services under subdivision 11 shall be the sum of ten percent of the rates
122.5 calculated under subdivisions 13 to 16 and 90 percent of the rates calculated using the rate
122.6 methodology in effect as of June 30, 2017.

122.7 Sec. 15. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
122.8 to read:

122.9 Subd. 13. **Payment rates; establishment.** (a) When establishing the base wages
122.10 according to subdivision 14, the commissioner shall use standard occupational classification
122.11 (SOC) codes from the Bureau of Labor Statistics as defined in the edition of the Occupational
122.12 Handbook published immediately prior to January 1, 2019, using Minnesota-specific wages
122.13 taken from job descriptions.

122.14 (b) Beginning January 1, 2019, and every January 1 thereafter, the commissioner shall
122.15 establish factors, component rates, and rates according to subdivisions 15 and 16, using
122.16 base wages established according to paragraph (a) and subdivision 14.

122.17 Sec. 16. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
122.18 to read:

122.19 Subd. 14. **Payment rates; base wage index.** (a) Base wages are calculated for customized
122.20 living, foster care, and residential care component services as follows:

122.21 (1) the home management and support services base wage equals 33.33 percent of the
122.22 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
122.23 care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington,
122.24 MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and
122.25 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage
122.26 for maids and housekeeping cleaners (SOC code 37-2012);

122.27 (2) the home care aide base wage equals 50 percent of the Minneapolis-St.
122.28 Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code
122.29 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
122.30 average wage for nursing assistants (SOC code 31-1014);

122.31 (3) the home health aide base wage equals 20 percent of the Minneapolis-St.
122.32 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed

- 123.1 vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.
123.2 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
123.3 31-1014); and
- 123.4 (4) the medication setups by licensed practical nurse base wage equals ten percent of
123.5 the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
123.6 and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St.
123.7 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
123.8 29-1141).
- 123.9 (b) Base wages are calculated for the following services as follows:
- 123.10 (1) the chore services base wage equals 100 percent of the Minneapolis-St.
123.11 Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping
123.12 workers (SOC code 37-3011);
- 123.13 (2) the companion services base wage equals 50 percent of the Minneapolis-St.
123.14 Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC
123.15 code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
123.16 average wage for maids and housekeeping cleaners (SOC code 37-2012);
- 123.17 (3) the homemaker services and assistance with personal care base wage equals 60
123.18 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
123.19 personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St.
123.20 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
123.21 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
123.22 average wage for maids and housekeeping cleaners (SOC code 37-2012);
- 123.23 (4) the homemaker services and cleaning base wage equals 60 percent of the
123.24 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
123.25 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
123.26 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
123.27 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
123.28 housekeeping cleaners (SOC code 37-2012);
- 123.29 (5) the homemaker services and home management base wage equals 60 percent of the
123.30 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
123.31 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
123.32 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
123.33 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
123.34 housekeeping cleaners (SOC code 37-2012);

124.1 (6) the in-home respite care services base wage equals five percent of the Minneapolis-St.
 124.2 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
 124.3 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average
 124.4 wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St.
 124.5 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed
 124.6 vocational nurses (SOC code 29-2061);

124.7 (7) the out-of-home respite care services base wage equals five percent of the
 124.8 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses
 124.9 (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
 124.10 average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
 124.11 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
 124.12 and licensed vocational nurses (SOC code 29-2061); and

124.13 (8) the individual community living support base wage equals 20 percent of the
 124.14 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
 124.15 and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.
 124.16 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
 124.17 31-1014).

124.18 (c) Base wages are calculated for the following values as follows:

124.19 (1) the registered nurse base wage equals 100 percent of the Minneapolis-St.
 124.20 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
 124.21 29-1141); and

124.22 (2) the social worker base wage equals 100 percent of the Minneapolis-St.
 124.23 Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social
 124.24 workers (SOC code 21-1022).

124.25 (d) If any of the SOC codes and positions are no longer available, the commissioner
 124.26 shall, in consultation with stakeholders, select a new SOC code and position that is the
 124.27 closest match to the previously used SOC position.

124.28 Sec. 17. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
 124.29 to read:

124.30 Subd. 15. **Payment rates; factors.** The commissioner shall use the following factors:

124.31 (1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits
 124.32 divided by the sum of all salaries for all nursing facilities on the most recent and available
 124.33 cost report;

125.1 (2) the general and administrative factor is the sum of net general and administrative
125.2 expenses minus administrative salaries divided by total operating expenses for all nursing
125.3 facilities on the most recent and available cost report;

125.4 (3) the program plan support factor is 12.8 percent to cover the cost of direct service
125.5 staff needed to provide support for the home and community-based service when not engaged
125.6 in direct contact with clients.

125.7 (4) the registered nurse management and supervision factor equals 15 percent of the
125.8 product of the position's base wage and the sum of the factors in clauses (1) to (3); and

125.9 (5) the social worker supervision factor equals 15 percent of the product of the position's
125.10 base wage and the sum of the factors in clauses (1) to (3).

125.11 Sec. 18. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
125.12 to read:

125.13 Subd. 16. **Payment rates; component rates.** (a) For the purposes of this subdivision,
125.14 the "adjusted base wage" for a position equals the position's base wage plus:

125.15 (1) the position's base wage multiplied by the payroll taxes and benefits factor;

125.16 (2) the position's base wage multiplied by the general and administrative factor; and

125.17 (3) the position's base wage multiplied by the program plan support factor.

125.18 (b) For medication setups by licensed nurse, registered nurse, and social worker services,
125.19 the component rate for each service equals the respective position's adjusted base wage.

125.20 (c) For home management and support services, home care aide, and home health aide
125.21 services, the component rate for each service equals the respective position's adjusted base
125.22 wage plus the registered nurse management and supervision factor.

125.23 (d) The home management and support services component rate shall be used for payment
125.24 for socialization and transportation component rates under elderly waiver customized living.

125.25 (e) The 15-minute unit rates for chore services and companion services are calculated
125.26 as follows:

125.27 (1) sum the adjusted base wage for the respective position and the social worker factor;
125.28 and

125.29 (2) divide the result of clause (1) by four.

126.1 (f) The 15-minute unit rates for homemaker services and assistance with personal care,
126.2 homemaker services and cleaning, and homemaker services and home management are
126.3 calculated as follows:

126.4 (1) sum the adjusted base wage for the respective position and the registered nurse
126.5 management and supervision factor; and

126.6 (2) divide the result of clause (1) by four.

126.7 (g) The 15-minute unit rate for in-home respite care services is calculated as follows:

126.8 (1) sum the adjusted base wage for in-home respite care services and the registered nurse
126.9 management and supervision factor; and

126.10 (2) divide the result of clause (1) by four.

126.11 (h) The in-home respite care services daily rate equals the in-home respite care services
126.12 15-minute unit rate multiplied by 18.

126.13 (i) The 15-minute unit rate for out-of-home respite care is calculated as follows:

126.14 (1) sum the out-of-home respite care services adjusted base wage and the registered
126.15 nurse management and supervision factor; and

126.16 (2) divide the result of clause (1) by four.

126.17 (j) The out-of-home respite care services daily rate equals the out-of-home respite care
126.18 services 15-minute unit rate multiplied by 18.

126.19 (k) The individual community living support rate is calculated as follows:

126.20 (1) sum the adjusted base wage for the home care aide rate in subdivision 14, paragraph
126.21 (a), clause (2), and the social worker factor; and

126.22 (2) divide the result of clause (1) by four.

126.23 (l) The home delivered meals rate equals \$9.30. Beginning July 1, 2018, the commissioner
126.24 shall increase the home delivered meals rate every July 1 by the percent increase in the
126.25 nursing facility dietary per diem using the two most recent and available nursing facility
126.26 cost reports.

126.27 (m) The adult day services rate is based on the home care aide rate in subdivision 14,
126.28 paragraph (a), clause (2), plus the additional factors from subdivision 15, except that the
126.29 general and administrative factor used shall be 20 percent. The nonregistered nurse portion
126.30 of the rate shall be multiplied by 0.25, to reflect an assumed-ratio staffing of one caregiver
126.31 to four clients, and divided by four to determine the 15-minute unit rate. The registered

127.1 nurse portion is divided by four to determine the 15-minute unit rate and \$0.63 per 15-minute
127.2 unit is added to cover the cost of meals.

127.3 (n) The adult day services bath 15-minute unit rate is the same as the calculation of the
127.4 adult day services 15-minute unit rate without the adjustment for staffing ratio.

127.5 (o) If a bath is authorized for an adult day services client, at least two 15-minute units
127.6 must be authorized to allow for adequate time to meet client needs. Adult day services may
127.7 be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver
127.8 needs.

127.9 Sec. 19. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
127.10 to read:

127.11 Subd. 17. **Evaluation of rate methodology.** The commissioner, in consultation with
127.12 stakeholders, shall conduct a study to evaluate the following:

127.13 (1) base wages in subdivision 14, to determine if the standard occupational classification
127.14 codes for each rate and component rate are an appropriate representation of staff who deliver
127.15 the services; and

127.16 (2) factors in subdivision 15, and adjusted base wage calculation in subdivision 16, to
127.17 determine if the factors and calculations appropriately address nonwage provider costs.

127.18 By January 1, 2019, the commissioner shall submit a report to the legislature on the
127.19 changes to the rate methodology in this statute, based on the results of the evaluation. Where
127.20 feasible, the report shall address the impact of the new rates on the workforce situation and
127.21 client access to services. The report should include any changes to the rate calculations
127.22 methods that the commissioner recommends.

127.23 Sec. 20. Minnesota Statutes 2016, section 256B.431, subdivision 10, is amended to read:

127.24 Subd. 10. **Property rate adjustments and construction projects.** A nursing facility
127.25 completing a construction project that is eligible for a rate adjustment under section
127.26 256B.434, subdivision 4f, and that was not approved through the moratorium exception
127.27 process in section 144A.073 must request from the commissioner a property-related payment
127.28 rate adjustment. ~~If the request is made within 60 days after the construction project's~~
127.29 ~~completion date,~~ The effective date of the rate adjustment is the first of the month of January
127.30 or July, whichever occurs first following both the construction project's completion date
127.31 and submission of the provider's rate adjustment request. ~~If the request is made more than~~
127.32 ~~60 days after the completion date, the rate adjustment is effective on the first of the month~~

128.1 ~~following the request.~~ The commissioner shall provide a rate notice reflecting the allowable
128.2 costs within 60 days after receiving all the necessary information to compute the rate
128.3 adjustment. No sooner than the effective date of the rate adjustment for the construction
128.4 project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any
128.5 amounts collected from private pay residents in excess of the allowable rate must be repaid
128.6 to private pay residents with interest at the rate used by the commissioner of revenue for
128.7 the late payment of taxes and in effect on the date the rate increase is effective. Construction
128.8 projects with completion dates within one year of the completion date associated with the
128.9 property rate adjustment request and phased projects with project completion dates within
128.10 three years of the last phase of the phased project must be aggregated for purposes of the
128.11 minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section
128.12 144A.071, subdivision 2. "Construction project" and "project construction costs" have the
128.13 meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

128.14 **EFFECTIVE DATE.** This section is effective for projects completed after January 1,
128.15 2018.

128.16 Sec. 21. Minnesota Statutes 2016, section 256B.431, subdivision 16, is amended to read:

128.17 Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning
128.18 after June 30, 1993, if a nursing facility acquires capital assets in connection with a project
128.19 approved under the moratorium exception process in section 144A.073 or in connection
128.20 with an addition to or replacement of buildings, attached fixtures, or land improvements
128.21 for which the total historical cost of those capital asset additions exceeds the lesser of
128.22 \$150,000 or ten percent of the most recent appraised value, the nursing facility shall be
128.23 eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation
128.24 is separate from the determination of the nursing facility's rental rate. An equity incentive
128.25 payment rate as computed under this subdivision is limited to one in a 12-month period.

128.26 (a) An eligible nursing facility shall receive an equity incentive payment rate equal to
128.27 the allowable historical cost of the capital asset acquired, minus the allowable debt directly
128.28 identified to that capital asset, multiplied by the equity incentive factor as described in
128.29 paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under
128.30 subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total
128.31 payment rate and shall be effective the same day as the incremental increase in paragraph
128.32 (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable
128.33 debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080,
128.34 and this section.

129.1 (b) The equity incentive factor shall be determined under clauses (1) to (4):

129.2 (1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the
129.3 capital asset additions referred to in paragraph (a), then cube the quotient,

129.4 (2) subtract the amount calculated in clause (1) from the number one,

129.5 (3) determine the difference between the rental factor and the lesser of two percentage
129.6 points above the posted yield for standard conventional fixed rate mortgages of the Federal
129.7 Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on
129.8 the first day of the month the debt or cost is incurred, or 16 percent,

129.9 (4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

129.10 (c) The equity incentive payment rate shall be limited to the term of the allowable debt
129.11 in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in
129.12 acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The
129.13 sale of a nursing facility under subdivision 14 shall terminate application of the equity
129.14 incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for
129.15 the sale.

129.16 (d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures,
129.17 or land improvements meeting the criteria in this subdivision and not receiving the
129.18 property-related payment rate adjustment in subdivision 17, shall receive the incremental
129.19 increase in the nursing facility's rental rate as determined under Minnesota Rules, parts
129.20 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the
129.21 nursing facility's property-related payment rate. The effective date of this incremental
129.22 increase shall be the first day of the month of January or July, whichever occurs first
129.23 following the ~~month in~~ date on which the addition or replacement is completed.

129.24 **EFFECTIVE DATE.** This section is effective for additions or replacements completed
129.25 after January 1, 2018.

129.26 Sec. 22. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

129.27 Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July
129.28 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway
129.29 shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph
129.30 (c), and calculation of the rental per diem, have those beds given the same effect as if the
129.31 beds had been delicensed so long as the beds remain on layaway. At the time of a layaway,
129.32 a facility may change its single bed election for use in calculating capacity days under
129.33 Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be

130.1 effective the first day of the month of January or July, whichever occurs first following the
130.2 ~~month in~~ date on which the layaway of the beds becomes effective under section 144A.071,
130.3 subdivision 4b.

130.4 (b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to
130.5 the contrary under section 256B.434, a nursing facility reimbursed under that section ~~which~~
130.6 that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed
130.7 to:

130.8 (1) aggregate the applicable investment per bed limits based on the number of beds
130.9 licensed immediately prior to entering the alternative payment system;

130.10 (2) retain or change the facility's single bed election for use in calculating capacity days
130.11 under Minnesota Rules, part 9549.0060, subpart 11; and

130.12 (3) establish capacity days based on the number of beds immediately prior to the layaway
130.13 and the number of beds after the layaway.

130.14 The commissioner shall increase the facility's property payment rate by the incremental
130.15 increase in the rental per diem resulting from the recalculation of the facility's rental per
130.16 diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and
130.17 (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
130.18 project after its base year, the base year property rate shall be the moratorium project property
130.19 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
130.20 paragraph (c). The property payment rate increase shall be effective the first day of the
130.21 month of January or July, whichever occurs first following the ~~month in~~ date on which the
130.22 layaway of the beds becomes effective.

130.23 (c) If a nursing facility removes a bed from layaway status in accordance with section
130.24 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the
130.25 number of licensed and certified beds in the facility not on layaway and shall reduce the
130.26 nursing facility's property payment rate in accordance with paragraph (b).

130.27 (d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision
130.28 to the contrary under section 256B.434, a nursing facility reimbursed under that section,
130.29 ~~which~~ that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the
130.30 commissioner of health according to the notice requirements in section 144A.071, subdivision
130.31 4b, shall be allowed to:

130.32 (1) aggregate the applicable investment per bed limits based on the number of beds
130.33 licensed immediately prior to entering the alternative payment system;

131.1 (2) retain or change the facility's single bed election for use in calculating capacity days
131.2 under Minnesota Rules, part 9549.0060, subpart 11; and

131.3 (3) establish capacity days based on the number of beds immediately prior to the
131.4 delicensure and the number of beds after the delicensure.

131.5 The commissioner shall increase the facility's property payment rate by the incremental
131.6 increase in the rental per diem resulting from the recalculation of the facility's rental per
131.7 diem applying only the changes resulting from the delicensure of beds and clauses (1), (2),
131.8 and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
131.9 project after its base year, the base year property rate shall be the moratorium project property
131.10 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
131.11 paragraph (c). The property payment rate increase shall be effective the first day of the
131.12 month of January or July, whichever occurs first following the ~~month in~~ date on which the
131.13 delicensure of the beds becomes effective.

131.14 (e) For nursing facilities reimbursed under this section or section 256B.434, any beds
131.15 placed on layaway shall not be included in calculating facility occupancy as it pertains to
131.16 leave days defined in Minnesota Rules, part 9505.0415.

131.17 (f) For nursing facilities reimbursed under this section or section 256B.434, the rental
131.18 rate calculated after placing beds on layaway may not be less than the rental rate prior to
131.19 placing beds on layaway.

131.20 (g) A nursing facility receiving a rate adjustment as a result of this section shall comply
131.21 with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

131.22 (h) A facility that does not utilize the space made available as a result of bed layaway
131.23 or delicensure under this subdivision to reduce the number of beds per room or provide
131.24 more common space for nursing facility uses or perform other activities related to the
131.25 operation of the nursing facility shall have its property rate increase calculated under this
131.26 subdivision reduced by the ratio of the square footage made available that is not used for
131.27 these purposes to the total square footage made available as a result of bed layaway or
131.28 delicensure.

131.29 **EFFECTIVE DATE.** This section is effective for layaways occurring after July 1, 2017.

131.30 Sec. 23. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

131.31 Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning
131.32 on and after January 1, 2019, a nursing facility's ~~ease mix~~ property payment rates rate for
131.33 the second and subsequent years of a facility's contract under this section are the previous

132.1 rate year's ~~contract~~ property payment rates ~~rate~~ plus an inflation adjustment ~~and, for facilities~~
 132.2 ~~reimbursed under this section or section 256B.431, an adjustment to include the cost of any~~
 132.3 ~~increase in Health Department licensing fees for the facility taking effect on or after July~~
 132.4 ~~1, 2001. The index for the inflation adjustment must be based on the change in the Consumer~~
 132.5 ~~Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner~~
 132.6 ~~of management and budget's national economic consultant~~ Reports and Forecasts Division
 132.7 of the Department of Human Services, as forecasted in the fourth quarter of the calendar
 132.8 year preceding the rate year. The inflation adjustment must be based on the 12-month period
 132.9 from the midpoint of the previous rate year to the midpoint of the rate year for which the
 132.10 rate is being determined. ~~For the rate years beginning on July 1, 1999, July 1, 2000, July 1,~~
 132.11 ~~2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July~~
 132.12 ~~1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the~~
 132.13 ~~property-related payment rate. For the rate years beginning on October 1, 2011, October 1,~~
 132.14 ~~2012, October 1, 2013, October 1, 2014, October 1, 2015, January 1, 2016, and January 1,~~
 132.15 ~~2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005,~~
 132.16 ~~adjustment to the property payment rate under this section and section 256B.431 shall be~~
 132.17 ~~effective on October 1. In determining the amount of the property-related payment rate~~
 132.18 ~~adjustment under this paragraph, the commissioner shall determine the proportion of the~~
 132.19 ~~facility's rates that are property-related based on the facility's most recent cost report.~~

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

132.21 Sec. 24. Minnesota Statutes 2016, section 256B.434, subdivision 4f, is amended to read:

132.22 Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a)
 132.23 Effective October 1, 2006, facilities reimbursed under this section may receive a property
 132.24 rate adjustment for construction projects exceeding the threshold in section 256B.431,
 132.25 subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For
 132.26 these projects, capital assets purchased shall be counted as construction project costs for a
 132.27 rate adjustment request made by a facility if they are: (1) purchased within 24 months of
 132.28 the completion of the construction project; (2) purchased after the completion date of any
 132.29 prior construction project; and (3) are not purchased prior to July 14, 2005. Except as
 132.30 otherwise provided in this subdivision, the definitions, rate calculation methods, and
 132.31 principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to
 132.32 9549.0080, shall be used to calculate rate adjustments for allowable construction projects
 132.33 under this subdivision and section 144A.073. Facilities completing construction projects
 132.34 between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment
 132.35 effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible

133.1 for a property rate adjustment effective on the first day of the month following the completion
133.2 date. Facilities completing projects after January 1, 2018, are eligible for a property rate
133.3 adjustment effective on the first day of the month of January or July, whichever occurs
133.4 immediately following the completion date.

133.5 (b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under
133.6 section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a
133.7 construction project on or after October 1, 2004, and do not have a contract under subdivision
133.8 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431,
133.9 subdivision 10, through September 30, 2006. If the request results in the commissioner
133.10 determining a rate adjustment is allowable, the rate adjustment is effective on the first of
133.11 the month following project completion. These facilities shall be allowed to accumulate
133.12 construction project costs for the period October 1, 2004, to September 30, 2006.

133.13 (c) Facilities shall be allowed construction project rate adjustments no sooner than 12
133.14 months after completing a previous construction project. Facilities must request the rate
133.15 adjustment according to section 256B.431, subdivision 10.

133.16 (d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060,
133.17 subpart 11. For rate calculations under this section, the number of licensed beds in the
133.18 nursing facility shall be the number existing after the construction project is completed and
133.19 the number of days in the nursing facility's reporting period shall be 365.

133.20 (e) The value of assets to be recognized for a total replacement project as defined in
133.21 section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value
133.22 of assets to be recognized for all other projects shall be computed as described in clause
133.23 (2).

133.24 (1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
133.25 number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the
133.26 maximum amount of assets allowable in a facility's property rate calculation. If a facility's
133.27 current request for a rate adjustment results from the completion of a construction project
133.28 that was previously approved under section 144A.073, the assets to be used in the rate
133.29 calculation cannot exceed the lesser of the amount determined under sections 144A.071,
133.30 subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction
133.31 project. A current request that is not the result of a project under section 144A.073 cannot
133.32 exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits
133.33 must be deducted from the cost of the construction project.

134.1 (2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
134.2 number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be
134.3 used to compute the maximum amount of assets allowable in a facility's property rate
134.4 calculation.

134.5 (ii) The value of a facility's assets to be compared to the amount in item (i) begins with
134.6 the total appraised value from the last rate notice a facility received when its rates were set
134.7 under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value
134.8 shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each
134.9 rate year the facility received an inflation factor on its property-related rate when its rates
134.10 were set under this section. The value of assets listed as previous capital additions, capital
134.11 additions, and special projects on the facility's base year rate notice and the value of assets
134.12 related to a construction project for which the facility received a rate adjustment when its
134.13 rates were determined under this section shall be added to the indexed appraised value.

134.14 (iii) The maximum amount of assets to be recognized in computing a facility's rate
134.15 adjustment after a project is completed is the lesser of the aggregate replacement-cost-new
134.16 limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the
134.17 construction project.

134.18 (iv) If a facility's current request for a rate adjustment results from the completion of a
134.19 construction project that was previously approved under section 144A.073, the assets to be
134.20 added to the rate calculation cannot exceed the lesser of the amount determined under
134.21 sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable
134.22 costs of the construction project. A current request that is not the result of a project under
134.23 section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2,
134.24 paragraph (a). Assets disposed of as a result of a construction project and applicable credits
134.25 must be deducted from the cost of the construction project.

134.26 (f) For construction projects approved under section 144A.073, allowable debt may
134.27 never exceed the lesser of the cost of the assets purchased, the threshold limit in section
134.28 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital
134.29 debt.

134.30 (g) For construction projects that were not approved under section 144A.073, allowable
134.31 debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such
134.32 construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously
134.33 existing capital debt. Amounts of debt taken out that exceed the costs of a construction
134.34 project shall not be allowed regardless of the use of the funds.

135.1 For all construction projects being recognized, interest expense and average debt shall
135.2 be computed based on the first 12 months following project completion. "Previously existing
135.3 capital debt" means capital debt recognized on the last rate determined under section
135.4 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt
135.5 recognized for a construction project for which the facility received a rate adjustment when
135.6 its rates were determined under this section.

135.7 For a total replacement project as defined in section 256B.431, subdivision 17d, the
135.8 value of previously existing capital debt shall be zero.

135.9 (h) In addition to the interest expense allowed from the application of paragraph (f), the
135.10 amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and
135.11 (3), will be added to interest expense.

135.12 (i) The equity portion of the construction project shall be computed as the allowable
135.13 assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be
135.14 multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added.
135.15 This sum must be divided by 95 percent of capacity days to compute the construction project
135.16 rate adjustment.

135.17 (j) For projects that are not a total replacement of a nursing facility, the amount in
135.18 paragraph (i) is adjusted for nonreimbursable areas and then added to the current property
135.19 payment rate of the facility.

135.20 (k) For projects that are a total replacement of a nursing facility, the amount in paragraph
135.21 (i) becomes the new property payment rate after being adjusted for nonreimbursable areas.
135.22 Any amounts existing in a facility's rate before the effective date of the construction project
135.23 for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements
135.24 under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431,
135.25 subdivision 19, shall be removed from the facility's rates.

135.26 (l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060,
135.27 subpart 10, as the result of construction projects under this section. Allowable equipment
135.28 shall be included in the construction project costs.

135.29 (m) Capital assets purchased after the completion date of a construction project shall be
135.30 counted as construction project costs for any future rate adjustment request made by a facility
135.31 under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months
135.32 of the completion of the future construction project.

136.1 (n) In subsequent rate years, the property payment rate for a facility that results from
136.2 the application of this subdivision shall be the amount inflated in subdivision 4.

136.3 (o) Construction projects are eligible for an equity incentive under section 256B.431,
136.4 subdivision 16. When computing the equity incentive for a construction project under this
136.5 subdivision, only the allowable costs and allowable debt related to the construction project
136.6 shall be used. The equity incentive shall not be a part of the property payment rate and not
136.7 inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing
136.8 facilities reimbursed under this section shall be allowed for a duration determined under
136.9 section 256B.431, subdivision 16, paragraph (c).

136.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

136.11 Sec. 25. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

136.12 Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a
136.13 written notice of appeal; the appeal must be postmarked or received by the commissioner
136.14 within 60 days of the publication date ~~the determination of the payment rate was mailed or~~
136.15 ~~personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice
136.16 of appeal must specify each disputed item; the reason for the dispute; the total dollar amount
136.17 in dispute for each separate disallowance, allocation, or adjustment of each cost item or part
136.18 of a cost item; the computation that the provider believes is correct; the authority in statute
136.19 or rule upon which the provider relies for each disputed item; the name and address of the
136.20 person or firm with whom contacts may be made regarding the appeal; and other information
136.21 required by the commissioner.

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

136.23 Sec. 26. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
136.24 to read:

136.25 Subd. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415,
136.26 subpart 7, a vacant bed in an intermediate care facility for persons with developmental
136.27 disabilities shall be counted as a reserved bed when determining occupancy rates and
136.28 eligibility for payment of a therapeutic leave day.

136.29 Sec. 27. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
136.30 to read:

136.31 Subd. 17. **ICF/DD rate increase effective July 1, 2017; Murray County.** Effective
136.32 July 1, 2017, the daily rate for an intermediate care facility for persons with developmental

137.1 disabilities located in Murray County that is classified as a class B facility and licensed for
 137.2 14 beds is \$400. This increase is in addition to any other increase that is effective on July
 137.3 1, 2017.

137.4 Sec. 28. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

137.5 Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for
 137.6 administering the overall activities of the nursing home. These costs include salaries and
 137.7 wages of the administrator, assistant administrator, business office employees, security
 137.8 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related
 137.9 to business office functions, licenses, ~~and~~ permits except as provided in the external fixed
 137.10 costs category, employee recognition, travel including meals and lodging, all training except
 137.11 as specified in subdivision 17, voice and data communication or transmission, office supplies,
 137.12 property and liability insurance and other forms of insurance ~~not designated to other areas~~
 137.13 except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal
 137.14 services, accounting services, management or business consultants, data processing,
 137.15 information technology, Web site, central or home office costs, business meetings and
 137.16 seminars, postage, fees for professional organizations, subscriptions, security services,
 137.17 advertising, board of directors fees, working capital interest expense, ~~and~~ bad debts, ~~and~~
 137.18 bad debt collection fees, and costs incurred for travel and housing for persons employed by
 137.19 a supplemental nursing services agency as defined in section 144A.70, subdivision 6.

137.20 **EFFECTIVE DATE.** This section is effective October 1, 2017.

137.21 Sec. 29. Minnesota Statutes 2016, section 256R.02, subdivision 17, is amended to read:

137.22 Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing
 137.23 administration, direct care registered nurses, licensed practical nurses, certified nursing
 137.24 assistants, trained medication aides, employees conducting training in resident care topics
 137.25 and associated fringe benefits and payroll taxes; services from a supplemental nursing
 137.26 services agency; supplies that are stocked at nursing stations or on the floor and distributed
 137.27 or used individually, including, but not limited to: alcohol, applicators, cotton balls,
 137.28 incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue
 137.29 depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers,
 137.30 plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes,
 137.31 clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee
 137.32 schedule by the medical assistance program or any other payer, and technology related to
 137.33 the provision of nursing care to residents, such as electronic charting systems; costs of

138.1 materials used for resident care training, and training courses outside of the facility attended
 138.2 by direct care staff on resident care topics; and costs for nurse consultants, pharmacy
 138.3 consultants, and medical directors. Salaries and payroll taxes for nurse consultants who
 138.4 work out of a central office must be allocated proportionately by total resident days or by
 138.5 direct identification to the nursing facilities served by those consultants.

138.6 **EFFECTIVE DATE.** This section is effective October 1, 2017.

138.7 Sec. 30. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

138.8 Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means
 138.9 premium expenses for group coverage ~~and reinsurance;~~ actual expenses incurred for
 138.10 self-insured plans, including reinsurance; and employer contributions to employee health
 138.11 reimbursement and health savings accounts. Premium and expense costs and contributions
 138.12 are allowable for (1) all employees and (2) the spouse and dependents of those employees
 138.13 ~~who meet the definition of full-time employees under the federal Affordable Care Act,~~
 138.14 ~~Public Law 111-148~~ are employed on average at least 30 hours per week.

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

138.16 Sec. 31. Minnesota Statutes 2016, section 256R.02, subdivision 19, is amended to read:

138.17 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing
 138.18 home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;
 138.19 family advisory council fee under section 144A.33; scholarships under section 256R.37;
 138.20 planned closure rate adjustments under section 256R.40; consolidation rate adjustments
 138.21 under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d;
 138.22 single-bed room incentives under section 256R.41; property taxes, assessments, and payments
 138.23 in lieu of taxes; employer health insurance costs; quality improvement incentive payment
 138.24 rate adjustments under section 256R.39; performance-based incentive payments under
 138.25 section 256R.38; special dietary needs under section 256R.51; rate adjustments for
 138.26 compensation-related costs for minimum wage changes under section 256R.49 provided
 138.27 on or after January 1, 2018; and Public Employees Retirement Association employer costs.

138.28 Sec. 32. Minnesota Statutes 2016, section 256R.02, subdivision 22, is amended to read:

138.29 Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life,
 138.30 dental, workers' compensation, ~~and other employee insurances and~~ short- and long-term
 138.31 disability, long-term care insurance, accident insurance, supplemental insurance, legal
 138.32 assistance insurance, profit sharing, health insurance costs not covered under subdivision

139.1 18, including costs associated with part-time employee family members or retirees, and
139.2 pension and retirement plan contributions, except for the Public Employees Retirement
139.3 Association and ~~employer health insurance costs; profit sharing; and retirement plans for~~
139.4 ~~which the employer pays all or a portion of the costs.~~

139.5 Sec. 33. Minnesota Statutes 2016, section 256R.02, subdivision 42, is amended to read:

139.6 Subd. 42. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing
139.7 facility residents and the allocation of dietary credits. Also included are special dietary
139.8 supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

139.9 Sec. 34. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision
139.10 to read:

139.11 Subd. 42a. **Real estate taxes.** "Real estate taxes" means the real estate tax liability shown
139.12 on the annual property tax statement of the nursing facility for the reporting period. The
139.13 term does not include personnel costs or fees for late payment.

139.14 Sec. 35. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision
139.15 to read:

139.16 Subd. 48a. **Special assessments.** "Special assessments" means the actual special
139.17 assessments and related interest paid during the reporting period. The term does not include
139.18 personnel costs or fees for late payment.

139.19 Sec. 36. Minnesota Statutes 2016, section 256R.02, subdivision 52, is amended to read:

139.20 Subd. 52. **Therapy costs.** "Therapy costs" means any costs related to ~~medical assistance~~
139.21 therapy services provided to residents that are not ~~billed~~ separately billable from the daily
139.22 operating rate.

139.23 Sec. 37. Minnesota Statutes 2016, section 256R.06, subdivision 5, is amended to read:

139.24 Subd. 5. **Notice to residents.** (a) No increase in nursing facility rates for private paying
139.25 residents shall be effective unless the nursing facility notifies the resident or person
139.26 responsible for payment of the increase in writing 30 days before the increase takes effect.
139.27 The notice must include the amount of the rate increase, the new payment rate, and the date
139.28 the rate increase takes effect.

139.29 A nursing facility may adjust its rates without giving the notice required by this
139.30 subdivision when the purpose of the rate adjustment is to reflect a change in the case mix

140.1 classification of the resident. The nursing facility shall notify private pay residents of any
140.2 rate increase related to a change in case mix classifications in a timely manner after
140.3 confirmation of the case mix classification change is received from the Department of
140.4 Health.

140.5 If the state fails to set rates as required by section 256R.09, subdivision 1, the time
140.6 required for giving notice is decreased by the number of days by which the state was late
140.7 in setting the rates.

140.8 (b) If the state does not set rates by the date required in section 256R.09, subdivision 1,
140.9 or otherwise provides nursing facilities with retroactive notification of the amount of a rate
140.10 increase, nursing facilities shall meet the requirement for advance notice by informing the
140.11 resident or person responsible for payments, on or before the effective date of the increase,
140.12 that a rate increase will be effective on that date. The requirements of paragraph (a) do not
140.13 apply to situations described in this paragraph.

140.14 If the exact amount has not yet been determined, the nursing facility may raise the rates
140.15 by the amount anticipated to be allowed. Any amounts collected from private pay residents
140.16 in excess of the allowable rate must be repaid to private pay residents with interest at the
140.17 rate used by the commissioner of revenue for the late payment of taxes and in effect on the
140.18 date the rate increase is effective.

140.19 Sec. 38. Minnesota Statutes 2016, section 256R.07, is amended by adding a subdivision
140.20 to read:

140.21 Subd. 6. **Electronic signature.** For documentation requiring a signature under this
140.22 chapter or section 256B.431 or 256B.434, use of an electronic signature as defined under
140.23 section 325L.02, paragraph (h), is allowed.

140.24 Sec. 39. Minnesota Statutes 2016, section 256R.10, is amended by adding a subdivision
140.25 to read:

140.26 Subd. 7. **Not specified allowed costs.** When the cost category for allowed cost items or
140.27 services is not specified in this chapter or the provider reimbursement manual, the
140.28 commissioner, in consultation with stakeholders, shall determine the cost category for the
140.29 allowed cost item or service.

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

141.1 Sec. 40. **[256R.18] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

141.2 Beginning January 1, 2019, the commissioner shall provide to the house of representatives
141.3 and senate committees with jurisdiction over nursing facility payment rates a biennial report
141.4 on the effectiveness of the reimbursement system in improving quality, restraining costs,
141.5 and any other features of the system as determined by the commissioner.

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

141.7 Sec. 41. Minnesota Statutes 2016, section 256R.37, is amended to read:

141.8 **256R.37 SCHOLARSHIPS.**

141.9 (a) For the 27-month period beginning October 1, 2015, through December 31, 2017,
141.10 the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing
141.11 facility with no scholarship per diem that is requesting a scholarship per diem to be added
141.12 to the external fixed payment rate to be used:

141.13 (1) for employee scholarships that satisfy the following requirements:

141.14 (i) scholarships are available to all employees who work an average of at least ten hours
141.15 per week at the facility except the administrator, and to reimburse student loan expenses
141.16 for newly hired ~~and recently graduated~~ registered nurses and licensed practical nurses, and
141.17 training expenses for nursing assistants as specified in section 144A.611, subdivisions 2
141.18 and 4, who are newly hired ~~and have graduated within the last 12 months~~; and

141.19 (ii) the course of study is expected to lead to career advancement with the facility or in
141.20 long-term care, including medical care interpreter services and social work; and

141.21 (2) to provide job-related training in English as a second language.

141.22 (b) All facilities may annually request a rate adjustment under this section by submitting
141.23 information to the commissioner on a schedule and in a form supplied by the commissioner.
141.24 The commissioner shall allow a scholarship payment rate equal to the reported and allowable
141.25 costs divided by resident days.

141.26 (c) In calculating the per diem under paragraph (b), the commissioner shall allow costs
141.27 related to tuition, direct educational expenses, and reasonable costs as defined by the
141.28 commissioner for child care costs and transportation expenses related to direct educational
141.29 expenses.

141.30 (d) The rate increase under this section is an optional rate add-on that the facility must
141.31 request from the commissioner in a manner prescribed by the commissioner. The rate
141.32 increase must be used for scholarships as specified in this section.

142.1 (e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities
142.2 that close beds during a rate year may request to have their scholarship adjustment under
142.3 paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect
142.4 the reduction in resident days compared to the cost report year.

142.5 **EFFECTIVE DATE.** This section is effective October 1, 2017.

142.6 Sec. 42. Minnesota Statutes 2016, section 256R.40, subdivision 1, is amended to read:

142.7 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

142.8 (b) "Closure" means the cessation of operations of a nursing facility and delicensure and
142.9 decertification of all beds within the facility.

142.10 (c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of
142.11 the resulting savings to provide planned closure rate adjustments at other facilities.

142.12 (d) "Commencement of closure" means the date on which residents and designated
142.13 representatives are notified of a planned closure as provided in section 144A.161, subdivision
142.14 5a, as part of an approved closure plan.

142.15 (e) "Completion of closure" means the date on which the final resident of the nursing
142.16 facility designated for closure in an approved closure plan is discharged from the facility
142.17 or the date that beds from a partial closure are delicensed and decertified.

142.18 (f) "Partial closure" means the delicensure and decertification of a portion of the beds
142.19 within the facility.

142.20 (g) "Planned closure rate adjustment" means an increase in a nursing facility's operating
142.21 rates resulting from a planned closure or a planned partial closure of another facility.

142.22 Sec. 43. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

142.23 Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the
142.24 amount of the planned closure rate adjustment available under subdivision 6 according to
142.25 clauses (1) to (4):

142.26 (1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

142.27 (2) the total number of beds in the nursing facility or facilities receiving the planned
142.28 closure rate adjustment must be identified;

142.29 (3) capacity days are determined by multiplying the number determined under clause
142.30 (2) by 365; and

143.1 (4) the planned closure rate adjustment is the amount available in clause (1), divided by
143.2 capacity days determined under clause (3).

143.3 (b) A planned closure rate adjustment under this section is effective on the first day of
143.4 the month of January or July, whichever occurs immediately following completion of closure
143.5 of the facility designated for closure in the application and becomes part of the nursing
143.6 facility's external fixed payment rate.

143.7 (c) Upon the request of a closing facility, the commissioner must allow the facility a
143.8 closure rate adjustment as provided under section 144A.161, subdivision 10.

143.9 (d) A facility that has received a planned closure rate adjustment may reassign it to
143.10 another facility that is under the same ownership at any time within three years of its effective
143.11 date. The amount of the adjustment is computed according to paragraph (a).

143.12 (e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the
143.13 commissioner shall recalculate planned closure rate adjustments for facilities that delicense
143.14 beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar
143.15 amount. The recalculated planned closure rate adjustment is effective from the date the per
143.16 bed dollar amount is increased.

143.17 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

143.18 Sec. 44. Minnesota Statutes 2016, section 256R.41, is amended to read:

143.19 **256R.41 SINGLE-BED ROOM INCENTIVE.**

143.20 (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed
143.21 under this chapter shall be increased by 20 percent multiplied by the ratio of the number of
143.22 new single-bed rooms created divided by the number of active beds on July 1, 2005, for
143.23 each bed closure that results in the creation of a single-bed room after July 1, 2005. The
143.24 commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each
143.25 year. For eligible bed closures for which the commissioner receives a notice from a facility
143.26 ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has
143.27 been established, the rate adjustment in this paragraph shall be effective on either the first
143.28 day of the ~~second~~ month of January or July, whichever occurs first following ~~that calendar~~
143.29 ~~quarter~~ the date of the bed delicensure.

143.30 (b) A nursing facility is prohibited from discharging residents for purposes of establishing
143.31 single-bed rooms. A nursing facility must submit documentation to the commissioner in a
143.32 form prescribed by the commissioner, certifying the occupancy status of beds closed to
143.33 create single-bed rooms. In the event that the commissioner determines that a facility has

144.1 discharged a resident for purposes of establishing a single-bed room, the commissioner shall
144.2 not provide a rate adjustment under paragraph (a).

144.3 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

144.4 Sec. 45. Minnesota Statutes 2016, section 256R.47, is amended to read:

144.5 **256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING**
144.6 **FACILITIES.**

144.7 (a) The commissioner, in consultation with the commissioner of health, may designate
144.8 certain nursing facilities as critical access nursing facilities. The designation shall be granted
144.9 on a competitive basis, within the limits of funds appropriated for this purpose.

144.10 (b) The commissioner shall request proposals from nursing facilities every two years.
144.11 Proposals must be submitted in the form and according to the timelines established by the
144.12 commissioner. In selecting applicants to designate, the commissioner, in consultation with
144.13 the commissioner of health, and with input from stakeholders, shall develop criteria designed
144.14 to preserve access to nursing facility services in isolated areas, rebalance long-term care,
144.15 and improve quality. To the extent practicable, the commissioner shall ensure an even
144.16 distribution of designations across the state.

144.17 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities
144.18 designated as critical access nursing facilities:

144.19 (1) partial rebasing, with the commissioner allowing a designated facility operating
144.20 payment rates being the sum of up to 60 percent of the operating payment rate determined
144.21 in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of
144.22 the two portions being equal to 100 percent, of the operating payment rate that would have
144.23 been allowed had the facility not been designated. The commissioner may adjust these
144.24 percentages by up to 20 percent and may approve a request for less than the amount allowed;

144.25 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
144.26 designation as a critical access nursing facility, the commissioner shall limit payment for
144.27 leave days to 60 percent of that nursing facility's total payment rate for the involved resident,
144.28 and shall allow this payment only when the occupancy of the nursing facility, inclusive of
144.29 bed hold days, is equal to or greater than 90 percent;

144.30 (3) two designated critical access nursing facilities, with up to 100 beds in active service,
144.31 may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part
144.32 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner

145.1 of health shall consider each waiver request independently based on the criteria under
 145.2 Minnesota Rules, part 4658.0040;

145.3 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall
 145.4 be 40 percent of the amount that would otherwise apply; and

145.5 (5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to
 145.6 designated critical access nursing facilities.

145.7 (d) Designation of a critical access nursing facility is for a period of two years, after
 145.8 which the benefits allowed under paragraph (c) shall be removed. Designated facilities may
 145.9 apply for continued designation.

145.10 (e) This section is suspended and no state or federal funding shall be appropriated or
 145.11 allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

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

145.13 Sec. 46. Minnesota Statutes 2016, section 256R.49, subdivision 1, is amended to read:

145.14 Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating payment~~
 145.15 ~~rates of all nursing facilities that are reimbursed under this chapter shall be increased effective~~
 145.16 ~~for rate years beginning on and after October 1, 2014, to address changes in compensation~~
 145.17 ~~costs for nursing facility employees paid less than \$14 per hour in accordance with this~~
 145.18 ~~section.~~ Rate increases provided under this section before October 1, 2016, expire effective
 145.19 January 1, 2018, and rate increases provided on or after October 1, 2016, expire effective
 145.20 January 1, 2019.

145.21 (b) Nursing facilities that receive approval of the applications in subdivision 2 must
 145.22 receive rate adjustments according to subdivision 4. The rate adjustments must be used to
 145.23 pay compensation costs for nursing facility employees paid less than \$14 per hour.

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

145.25 Sec. 47. **DIRECTION TO THE COMMISSIONER; ADULT DAY SERVICES**
 145.26 **STAFFING RATIOS; ELDERLY WAIVER.**

145.27 The commissioner of human services shall:

145.28 (1) study existing adult day services models, including resident acuity, staffing and
 145.29 support levels, and quality assurance;

145.30 (2) project demand for adult day services into the future; and

146.1 (3) report to the legislature by January 1, 2019.

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

146.3 Sec. 48. **ALZHEIMER'S DISEASE WORKING GROUP.**

146.4 Subdivision 1. **Members.** (a) The Minnesota Board on Aging must appoint 16 members
 146.5 to an Alzheimer's disease working group, as follows:

146.6 (1) a caregiver of a person who has been diagnosed with Alzheimer's disease;

146.7 (2) a person who has been diagnosed with Alzheimer's disease;

146.8 (3) two representatives from the nursing facility or senior housing profession;

146.9 (4) a representative of the home care or adult day services profession;

146.10 (5) two geriatricians, one of whom serves a diverse or underserved community;

146.11 (6) a psychologist who specializes in dementia care;

146.12 (7) an Alzheimer's researcher;

146.13 (8) a representative of the Alzheimer's Association;

146.14 (9) two members from community-based organizations serving one or more diverse or
 146.15 underserved communities;

146.16 (10) the commissioner of human services or a designee;

146.17 (11) the commissioner of health or a designee;

146.18 (12) the ombudsman for long-term care or a designee; and

146.19 (13) one member of the Minnesota Board on Aging, selected by the board.

146.20 (b) The executive director of the Minnesota Board on Aging serves on the working group
 146.21 as a nonvoting member.

146.22 (c) The appointing authorities under this subdivision must complete their appointments
 146.23 no later than December 15, 2017.

146.24 (d) To the extent practicable, the membership of the working group must reflect the
 146.25 diversity in Minnesota, and must include representatives from rural and metropolitan areas
 146.26 and representatives of different ethnicities, races, genders, ages, cultural groups, and abilities.

146.27 Subd. 2. **Duties; recommendations.** The Alzheimer's disease working group must
 146.28 review and revise the 2011 report, Preparing Minnesota for Alzheimer's: the Budgetary,

147.1 Social and Personal Impacts. The working group shall consider and make recommendations
147.2 and findings on the following issues as related to Alzheimer's disease or other dementias:

147.3 (1) analysis and assessment of public health and health care data to accurately determine
147.4 trends and disparities in cognitive decline;

147.5 (2) public awareness, knowledge, and attitudes, including knowledge gaps, stigma,
147.6 availability of information, and supportive community environments;

147.7 (3) risk reduction, including health education and health promotion on risk factors,
147.8 safety, and potentially avoidable hospitalizations;

147.9 (4) diagnosis and treatment, including early detection, access to diagnosis, quality of
147.10 dementia care, and cost of treatment;

147.11 (5) professional education and training, including geriatric education for licensed health
147.12 care professionals and dementia-specific training for direct care workers, first responders,
147.13 and other professionals in communities;

147.14 (6) residential services, including cost to families as well as regulation and licensing
147.15 gaps; and

147.16 (7) cultural competence and responsiveness to reduce health disparities and improve
147.17 access to high-quality dementia care.

147.18 Subd. 3. **Meetings.** The Board on Aging must convene the first meeting of the working
147.19 group no later than January 15, 2018. Before the first meeting, the Board on Aging must
147.20 designate one member to serve as chair. Meetings of the working group must be open to
147.21 the public, and to the extent practicable, technological means, such as Web casts, shall be
147.22 used to reach the greatest number of people throughout the state. The working group may
147.23 not meet more than five times.

147.24 Subd. 4. **Compensation.** Members of the working group serve without compensation,
147.25 but may be reimbursed for allowed actual and necessary expenses incurred in the performance
147.26 of the member's duties for the working group in the same manner and amount as authorized
147.27 by the commissioner's plan adopted under Minnesota Statutes, section 43A.18, subdivision
147.28 2.

147.29 Subd. 5. **Administrative support.** The Minnesota Board on Aging shall provide
147.30 administrative support and arrange meeting space for the working group.

147.31 Subd. 6. **Report.** The Board on Aging must submit a report providing the findings and
147.32 recommendations of the working group, including any draft legislation necessary to

148.1 implement the recommendations, to the governor and chairs and ranking minority members
 148.2 of the legislative committees with jurisdiction over health care by January 15, 2019.

148.3 Subd. 7. **Expiration.** The working group expires June 30, 2019, or the day after the
 148.4 working group submits the report required in subdivision 6, whichever is earlier.

148.5 Sec. 49. **ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM.**

148.6 Subdivision 1. **Documentation; establishment.** The commissioner of human services
 148.7 shall establish implementation requirements and standards for an electronic service delivery
 148.8 documentation system to comply with the 21st Century Cures Act, Public Law 114-255.
 148.9 Within available appropriations, the commissioner shall take steps to comply with the
 148.10 electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

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

148.13 (b) "Electronic service delivery documentation" means the electronic documentation of
 148.14 the:

148.15 (1) type of service performed;

148.16 (2) individual receiving the service;

148.17 (3) date of the service;

148.18 (4) location of the service delivery;

148.19 (5) individual providing the service; and

148.20 (6) time the service begins and ends.

148.21 (c) "Electronic service delivery documentation system" means a system that provides
 148.22 electronic service delivery documentation that complies with the 21st Century Cures Act,
 148.23 Public Law 114-255, and the requirements of subdivision 3.

148.24 (d) "Service" means one of the following:

148.25 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
 148.26 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; or

148.27 (2) community first services and supports under Minnesota Statutes, section 256B.85.

148.28 Subd. 3. **Requirements.** (a) In developing implementation requirements for an electronic
 148.29 service delivery documentation system, the commissioner shall consider electronic visit
 148.30 verification systems and other electronic service delivery documentation methods. The

149.1 commissioner shall convene stakeholders that will be impacted by an electronic service
149.2 delivery system, including service providers and their representatives, service recipients
149.3 and their representatives, and, as appropriate, those with expertise in the development and
149.4 operation of an electronic service delivery documentation system, to ensure that the
149.5 requirements:

149.6 (1) are minimally administratively and financially burdensome to a provider;

149.7 (2) are minimally burdensome to the service recipient and the least disruptive to the
149.8 service recipient in receiving and maintaining allowed services;

149.9 (3) consider existing best practices and use of electronic service delivery documentation;

149.10 (4) are conducted according to all state and federal laws;

149.11 (5) are effective methods for preventing fraud when balanced against the requirements
149.12 of clauses (1) and (2); and

149.13 (6) are consistent with the Department of Human Services' policies related to covered
149.14 services, flexibility of service use, and quality assurance.

149.15 (b) The commissioner shall make training available to providers on the electronic service
149.16 delivery documentation system requirements.

149.17 (c) The commissioner shall establish baseline measurements related to preventing fraud
149.18 and establish measures to determine the effect of electronic service delivery documentation
149.19 requirements on program integrity.

149.20 Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,
149.21 2018, to the chairs and ranking minority members of the legislative committees with
149.22 jurisdiction over human services with recommendations, based on the requirements of
149.23 subdivision 3, to establish electronic service delivery documentation system requirements
149.24 and standards. The report shall identify:

149.25 (1) the essential elements necessary to operationalize a base-level electronic service
149.26 delivery documentation system to be implemented by January 1, 2019; and

149.27 (2) enhancements to the base-level electronic service delivery documentation system to
149.28 be implemented by January 1, 2019, or after, with projected operational costs and the costs
149.29 and benefits for system enhancements.

149.30 (b) The report must also identify current regulations on service providers that are either
149.31 inefficient, minimally effective, or will be unnecessary with the implementation of an
149.32 electronic service delivery documentation system.

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

150.2 Sec. 50. **DIRECTION TO COMMISSIONER; ICF/DD PAYMENT RATE STUDY.**

150.3 Within available appropriations, the commissioner of human services shall study the
150.4 intermediate care facility for persons with developmental disabilities payment rates under
150.5 Minnesota Statutes, sections 256B.5011 to 256B.5013, and make recommendations on the
150.6 rate structure to the chairs and ranking minority members of the legislative committees with
150.7 jurisdiction over human services policy and finance by January 15, 2018.

150.8 Sec. 51. **REVISOR'S INSTRUCTION.**

150.9 The revisor of statutes, in consultation with the House Research Department, Office of
150.10 Senate Counsel, Research, and Fiscal Analysis, and Department of Human Services shall
150.11 prepare legislation for the 2018 legislative session to recodify laws governing the elderly
150.12 waiver program in Minnesota Statutes, chapter 256B.

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

150.14 **ARTICLE 4**

150.15 **HEALTH CARE**

150.16 Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision
150.17 to read:

150.18 Subd. 2a. **Audits of Department of Human Services.** (a) To ensure continuous
150.19 legislative oversight and accountability, the legislative auditor shall give high priority to
150.20 auditing the programs, services, and benefits administered by the Department of Human
150.21 Services. The audits shall determine whether the department offered programs and provided
150.22 services and benefits only to eligible persons and organizations, and complied with applicable
150.23 legal requirements.

150.24 (b) The legislative auditor shall, based on an assessment of risk and using professional
150.25 standards to provide a statistically significant sample, no less than three times each year,
150.26 test a representative sample of persons enrolled in a medical assistance program or
150.27 MinnesotaCare to determine whether they are eligible to receive benefits under those
150.28 programs. The legislative auditor shall report the results to the commissioner of human
150.29 services and recommend corrective actions. The commissioner shall provide a response to
150.30 the legislative auditor within 20 business days, including corrective actions to be taken to
150.31 address any problems identified by the legislative auditor and anticipated completion dates.

151.1 The legislative auditor shall monitor the commissioner's implementation of corrective actions
 151.2 and periodically report the results to the Legislative Audit Commission and the chairs and
 151.3 ranking minority members of the legislative committees with jurisdiction over health and
 151.4 human services policy and finance. The legislative auditor's reports to the commission and
 151.5 the chairs and ranking minority members must include recommendations for any legislative
 151.6 actions needed to ensure that medical assistance and MinnesotaCare benefits are provided
 151.7 only to eligible persons.

151.8 Sec. 2. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision to
 151.9 read:

151.10 Subd. 2b. **Audits of managed care organizations.** (a) The legislative auditor shall audit
 151.11 each managed care organization that contracts with the commissioner of human services to
 151.12 provide health care services under sections 256B.69, 256B.692, and 256L.12. The legislative
 151.13 auditor shall design the audits to determine if a managed care organization used the public
 151.14 money in compliance with federal and state laws, rules, and in accordance with provisions
 151.15 in the managed care organization's contract with the commissioner of human services. The
 151.16 legislative auditor shall determine the schedule and scope of the audit work and may contract
 151.17 with vendors to assist with the audits. The managed care organization must cooperate with
 151.18 the legislative auditor and must provide the legislative auditor with all data, documents, and
 151.19 other information, regardless of classification, that the legislative auditor requests to conduct
 151.20 an audit. The legislative auditor shall periodically report audit results and recommendations
 151.21 to the Legislative Audit Commission and the chairs and ranking minority members of the
 151.22 legislative committees with jurisdiction over health and human services policy and finance.

151.23 (b) For purposes of this subdivision, a "managed care organization" means a
 151.24 demonstration provider as defined under section 256B.69, subdivision 2.

151.25 Sec. 3. Minnesota Statutes 2016, section 62U.02, is amended to read:

151.26 **62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.**

151.27 Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized
 151.28 set of measures for use by health plan companies as specified in subdivision 5. As part of
 151.29 the standardized set of measures, the commissioner shall establish statewide measures by
 151.30 which to assess the quality of health care services offered by health care providers, including
 151.31 health care providers certified as health care homes under section 256B.0751. Quality
 151.32 measures must be based on medical evidence and be developed through a process in which
 151.33 providers participate. The statewide measures shall be used for the quality incentive payment

- 152.1 system developed in subdivision 2 and the quality transparency requirements in subdivision
 152.2 3. The statewide measures must:
- 152.3 (1) for purposes of assessing the quality of care provided at physician clinics, including
 152.4 clinics certified as health care homes under section 256B.0751, be selected from the available
 152.5 measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended,
 152.6 unless the stakeholders identified under paragraph (b) determine that a particular diagnosis,
 152.7 condition, service, or procedure is not reflected in any of the available measures in a way
 152.8 that meets identified needs;
- 152.9 (2) be based on medical evidence;
- 152.10 (3) be developed through a process in which providers participate and consumer and
 152.11 community input and perspectives are obtained;
- 152.12 ~~(4)~~ (4) include uniform definitions, measures, and forms for submission of data, to the
 152.13 greatest extent possible;
- 152.14 ~~(2)~~ (5) seek to avoid increasing the administrative burden on health care providers; and
- 152.15 ~~(3) be initially based on existing quality indicators for physician and hospital services,~~
 152.16 ~~which are measured and reported publicly by quality measurement organizations, including,~~
 152.17 ~~but not limited to, Minnesota Community Measurement and specialty societies;~~
- 152.18 ~~(4)~~ (6) place a priority on measures of health care outcomes, rather than process measures,
 152.19 wherever possible; and
- 152.20 ~~(5) incorporate measures for primary care, including preventive services, coronary artery~~
 152.21 ~~and heart disease, diabetes, asthma, depression, and other measures as determined by the~~
 152.22 ~~commissioner.~~
- 152.23 The measures may also include measures of care infrastructure and patient satisfaction.
- 152.24 (b) By June 30, 2018, the commissioner shall develop a measurement framework that
 152.25 identifies the most important elements for assessing the quality of care, articulates statewide
 152.26 quality improvement goals, ensures clinical relevance, fosters alignment with other
 152.27 measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the
 152.28 commissioner shall use the framework to update the statewide measures used to assess the
 152.29 quality of health care services offered by health care providers, including health care
 152.30 providers certified as health care homes under section 256B.0751. No more than six statewide
 152.31 measures shall be required for single-specialty physician practices and no more than ten
 152.32 statewide measures shall be required for multispecialty physician practices. Measures in
 152.33 addition to the six statewide measures for single-specialty practices and the ten statewide

153.1 measures for multispecialty practices may be included for a physician practice if derived
153.2 from administrative claims data. Care infrastructure measures collected according to section
153.3 62J.495 shall not be counted toward the maximum number of measures specified in this
153.4 paragraph. The commissioner shall develop the framework in consultation with stakeholders
153.5 that include consumer, community, and advocacy organizations representing diverse
153.6 communities and patients; health plan companies; health care providers whose quality is
153.7 assessed, including providers who serve primarily socioeconomically complex patient
153.8 populations; health care purchasers; community health boards; and quality improvement
153.9 and measurement organizations. The commissioner, in consultation with stakeholders, shall
153.10 review the framework at least once every three years. The commissioner shall also submit
153.11 a report to the chairs and ranking minority members of the legislative committees with
153.12 jurisdiction over health and human services policy and finance by September 30, 2018,
153.13 summarizing the development of the measurement framework and making recommendations
153.14 on the type and appropriate maximum number of measures in the statewide measures set
153.15 for implementation on January 1, 2020.

153.16 ~~(b)~~ (c) Effective July 1, 2016, the commissioner shall stratify quality measures by race,
153.17 ethnicity, preferred language, and country of origin beginning with five measures, and
153.18 stratifying additional measures to the extent resources are available. On or after January 1,
153.19 2018, the commissioner may require measures to be stratified by other sociodemographic
153.20 factors or composite indices of multiple factors that according to reliable data are correlated
153.21 with health disparities and have an impact on performance on quality or cost indicators.
153.22 New methods of stratifying data under this paragraph must be tested and evaluated through
153.23 pilot projects prior to adding them to the statewide system. In determining whether to add
153.24 additional sociodemographic factors and developing the methodology to be used, the
153.25 commissioner shall consider the reporting burden on providers and determine whether there
153.26 are alternative sources of data that could be used. The commissioner shall ensure that
153.27 categories and data collection methods are developed in consultation with those communities
153.28 impacted by health disparities using culturally appropriate community engagement principles
153.29 and methods. The commissioner shall implement this paragraph in coordination with the
153.30 contracting entity retained under subdivision 4, in order to build upon the data stratification
153.31 methodology that has been developed and tested by the entity. Nothing in this paragraph
153.32 expands or changes the commissioner's authority to collect, analyze, or report health care
153.33 data. Any data collected to implement this paragraph must be data that is available or is
153.34 authorized to be collected under other laws. Nothing in this paragraph grants authority to
153.35 the commissioner to collect or analyze patient-level or patient-specific data of the patient
153.36 characteristics identified under this paragraph.

154.1 ~~(e)~~ (d) The statewide measures shall be reviewed at least annually by the commissioner.

154.2 Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall
154.3 develop a system of quality incentive payments under which providers are eligible for
154.4 quality-based payments that are in addition to existing payment levels, based upon a
154.5 comparison of provider performance against specified targets, and improvement over time.
154.6 The targets must be based upon and consistent with the quality measures established under
154.7 subdivision 1.

154.8 (b) To the extent possible, the payment system must adjust for variations in patient
154.9 population in order to reduce incentives to health care providers to avoid high-risk patients
154.10 or populations, including those with risk factors related to race, ethnicity, language, country
154.11 of origin, and sociodemographic factors.

154.12 (c) The requirements of section 62Q.101 do not apply under this incentive payment
154.13 system.

154.14 Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for
154.15 measuring health outcomes, establish a system for risk adjusting quality measures, and issue
154.16 ~~annual~~ periodic public reports on trends in provider quality beginning July 1, 2010 at the
154.17 statewide, regional, or clinic levels.

154.18 (b) Effective July 1, 2017, the risk adjustment system established under this subdivision
154.19 shall adjust for patient characteristics identified under subdivision 1, paragraph ~~(b)~~ (c), that
154.20 are correlated with health disparities and have an impact on performance on cost and quality
154.21 measures. The risk adjustment method may consist of reporting based on an
154.22 actual-to-expected comparison that reflects the characteristics of the patient population
154.23 served by the clinic or hospital. The commissioner shall implement this paragraph in
154.24 coordination with any contracting entity retained under subdivision 4.

154.25 (c) ~~By January 1, 2010,~~ Physician clinics and hospitals shall submit standardized
154.26 ~~electronic information on the outcomes and processes associated with patient care~~ for the
154.27 identified statewide measures to the commissioner or the commissioner's designee in the
154.28 formats specified by the commissioner, which must include alternative formats for clinics
154.29 or hospitals experiencing technological or economic barriers to submission in standardized
154.30 electronic form. ~~In addition to measures of care processes and outcomes, the report may~~
154.31 ~~include other measures designated by the commissioner, including, but not limited to, care~~
154.32 ~~infrastructure and patient satisfaction. The commissioner shall ensure that any quality data~~
154.33 ~~reporting requirements established under this subdivision are not duplicative of publicly~~
154.34 ~~reported, communitywide quality reporting activities currently under way in Minnesota.~~

155.1 The commissioner shall ensure that any quality data reporting requirements for physician
 155.2 clinics are aligned with the specifications and timelines for the selected measures as defined
 155.3 in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional data
 155.4 on race, ethnicity, preferred language, country of origin, or other sociodemographic factors
 155.5 as identified under subdivision 1, paragraph (c), and as required for stratification or risk
 155.6 adjustment. None of the statewide measures selected shall require providers to use an external
 155.7 vendor to administer or collect data. ~~Nothing in this subdivision is intended to replace or~~
 155.8 ~~duplicate current privately supported activities related to quality measurement and reporting~~
 155.9 ~~in Minnesota.~~

155.10 Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium
 155.11 of private entities to complete the tasks in subdivisions 1 to 3. The private entity or
 155.12 consortium must be nonprofit and have governance that includes representatives from the
 155.13 following stakeholder groups: health care providers, including providers serving high
 155.14 concentrations of patients and communities impacted by health disparities; health plan
 155.15 companies; consumers, including consumers representing groups who experience health
 155.16 disparities; employers or other health care purchasers; and state government. No one
 155.17 stakeholder group shall have a majority of the votes on any issue or hold extraordinary
 155.18 powers not granted to any other governance stakeholder.

155.19 Subd. 5. **Implementation.** ~~(a) By January 1, 2010,~~ Health plan companies shall use the
 155.20 standardized quality set of measures established under this section and shall not require
 155.21 providers to use and report health plan company-specific quality and outcome measures.

155.22 ~~(b) By July 1, 2010, the commissioner of management and budget shall implement this~~
 155.23 ~~incentive payment system for all participants in the state employee group insurance program.~~

155.24 Sec. 4. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to
 155.25 read:

155.26 Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset
 155.27 Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to
 155.28 verify assets for an individual applying for or renewing health care benefits under section
 155.29 256B.055, subdivision 7.

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

156.1 Sec. 5. Minnesota Statutes 2016, section 256.9685, subdivision 1, is amended to read:

156.2 Subdivision 1. **Authority.** ~~(a)~~ The commissioner shall establish procedures for
156.3 determining medical assistance payment rates under a prospective payment system for
156.4 inpatient hospital services in hospitals that qualify as vendors of medical assistance. The
156.5 commissioner shall establish, by rule, procedures for implementing this section and sections
156.6 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04,
156.7 subdivision 15, to be eligible for payment.

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

156.11 Sec. 6. Minnesota Statutes 2016, section 256.9685, subdivision 1a, is amended to read:

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

156.22 Sec. 7. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

156.23 Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.
156.24 Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June
156.25 30.

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

156.27 Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

156.28 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in
156.29 the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The
156.30 commissioner shall use the indices as forecasted for the midpoint of the prior rate year to
156.31 the midpoint of the current rate year.

157.1 (b) Except as authorized under this section, for fiscal years beginning on or after July
157.2 1, 1993, the commissioner of human services shall not provide automatic annual inflation
157.3 adjustments for hospital payment rates under medical assistance.

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

157.5 Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

157.6 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
157.7 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
157.8 to the following:

157.9 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
157.10 methodology;

157.11 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
157.12 under subdivision 25;

157.13 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
157.14 distinct parts as defined by Medicare shall be paid according to the methodology under
157.15 subdivision 12; and

157.16 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

157.17 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
157.18 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
157.19 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
157.20 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
157.21 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
157.22 years are updated, a Minnesota long-term hospital's base year shall remain within the same
157.23 period as other hospitals.

157.24 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
157.25 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
157.26 area, except for the hospitals paid under the methodologies described in paragraph (a),
157.27 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
157.28 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
157.29 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
157.30 that the total aggregate payments under the rebased system are equal to the total aggregate
157.31 payments that were made for the same number and types of services in the base year. Separate
157.32 budget neutrality calculations shall be determined for payments made to critical access
157.33 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases

158.1 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during
158.2 the entire base period shall be incorporated into the budget neutrality calculation.

158.3 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
158.4 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
158.5 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
158.6 a five percent increase or decrease from the base year payments for any hospital. Any
158.7 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
158.8 shall maintain budget neutrality as described in paragraph (c).

158.9 (e) For discharges occurring on or after November 1, 2014, through the next two rebasing
158.10 ~~that occurs~~ periods the commissioner may make additional adjustments to the rebased rates,
158.11 and when evaluating whether additional adjustments should be made, the commissioner
158.12 shall consider the impact of the rates on the following:

158.13 (1) pediatric services;

158.14 (2) behavioral health services;

158.15 (3) trauma services as defined by the National Uniform Billing Committee;

158.16 (4) transplant services;

158.17 (5) obstetric services, newborn services, and behavioral health services provided by
158.18 hospitals outside the seven-county metropolitan area;

158.19 (6) outlier admissions;

158.20 (7) low-volume providers; and

158.21 (8) services provided by small rural hospitals that are not critical access hospitals.

158.22 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

158.23 (1) for hospitals paid under the DRG methodology, the base year payment rate per
158.24 admission is standardized by the applicable Medicare wage index and adjusted by the
158.25 hospital's disproportionate population adjustment;

158.26 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
158.27 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
158.28 October 31, 2014;

158.29 (3) the cost and charge data used to establish hospital payment rates must only reflect
158.30 inpatient services covered by medical assistance; and

159.1 (4) in determining hospital payment rates for discharges occurring on or after the rate
159.2 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
159.3 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
159.4 program in effect during the base year or years. In determining hospital payment rates for
159.5 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
159.6 methods and allowable costs of the Medicare program in effect during the base year or
159.7 years.

159.8 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
159.9 the rates established under paragraph (c), and any adjustments made to the rates under
159.10 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
159.11 total aggregate payments for the same number and types of services under the rebased rates
159.12 are equal to the total aggregate payments made during calendar year 2013.

159.13 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
159.14 thereafter, payment rates under this section shall be rebased to reflect only those changes
159.15 in hospital costs between the existing base year and the next base year. Changes in costs
159.16 between base years shall be measured using the lower of the hospital cost index defined in
159.17 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
159.18 claim. The commissioner shall establish the base year for each rebasing period considering
159.19 the most recent year for which filed Medicare cost reports are available. The estimated
159.20 change in the average payment per hospital discharge resulting from a scheduled rebasing
159.21 must be calculated and made available to the legislature by January 15 of each year in which
159.22 rebasing is scheduled to occur, and must include by hospital the differential in payment
159.23 rates compared to the individual hospital's costs.

159.24 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
159.25 for critical access hospitals located in Minnesota or the local trade area shall be determined
159.26 using a new cost-based methodology. The commissioner shall establish within the
159.27 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
159.28 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
159.29 the total cost for critical access hospitals as reflected in base year cost reports. Until the
159.30 next rebasing that occurs, the new methodology shall result in no greater than a five percent
159.31 decrease from the base year payments for any hospital, except a hospital that had payments
159.32 that were greater than 100 percent of the hospital's costs in the base year shall have their
159.33 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
159.34 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
159.35 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not

160.1 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
160.2 following criteria:

160.3 (1) hospitals that had payments at or below 80 percent of their costs in the base year
160.4 shall have a rate set that equals 85 percent of their base year costs;

160.5 (2) hospitals that had payments that were above 80 percent, up to and including 90
160.6 percent of their costs in the base year shall have a rate set that equals 95 percent of their
160.7 base year costs; and

160.8 (3) hospitals that had payments that were above 90 percent of their costs in the base year
160.9 shall have a rate set that equals 100 percent of their base year costs.

160.10 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
160.11 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
160.12 methodology may include, but are not limited to:

160.13 (1) the ratio between the hospital's costs for treating medical assistance patients and the
160.14 hospital's charges to the medical assistance program;

160.15 (2) the ratio between the hospital's costs for treating medical assistance patients and the
160.16 hospital's payments received from the medical assistance program for the care of medical
160.17 assistance patients;

160.18 (3) the ratio between the hospital's charges to the medical assistance program and the
160.19 hospital's payments received from the medical assistance program for the care of medical
160.20 assistance patients;

160.21 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

160.22 (5) the proportion of that hospital's costs that are administrative and trends in
160.23 administrative costs; and

160.24 (6) geographic location.

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

160.26 Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

160.27 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program
160.28 must not be submitted until the recipient is discharged. However, the commissioner shall
160.29 establish monthly interim payments for inpatient hospitals that have individual patient
160.30 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section
160.31 256.9693, medical assistance reimbursement for treatment of mental illness shall be

161.1 reimbursed based on diagnostic classifications. Individual hospital payments established
161.2 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party
161.3 and recipient liability, for discharges occurring during the rate year shall not exceed, in
161.4 aggregate, the charges for the medical assistance covered inpatient services paid for the
161.5 same period of time to the hospital. Services that have rates established under subdivision
161.6 ~~11~~ or 12, must be limited separately from other services. After consulting with the affected
161.7 hospitals, the commissioner may consider related hospitals one entity and may merge the
161.8 payment rates while maintaining separate provider numbers. The operating and property
161.9 base rates per admission or per day shall be derived from the best Medicare and claims data
161.10 available when rates are established. The commissioner shall determine the best Medicare
161.11 and claims data, taking into consideration variables of recency of the data, audit disposition,
161.12 settlement status, and the ability to set rates in a timely manner. The commissioner shall
161.13 notify hospitals of payment rates 30 days prior to implementation. The rate setting data
161.14 must reflect the admissions data used to establish relative values. The commissioner may
161.15 adjust base year cost, relative value, and case mix index data to exclude the costs of services
161.16 that have been discontinued by the October 1 of the year preceding the rate year or that are
161.17 paid separately from inpatient services. Inpatient stays that encompass portions of two or
161.18 more rate years shall have payments established based on payment rates in effect at the time
161.19 of admission unless the date of admission preceded the rate year in effect by six months or
161.20 more. In this case, operating payment rates for services rendered during the rate year in
161.21 effect and established based on the date of admission shall be adjusted to the rate year in
161.22 effect by the hospital cost index.

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

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

161.31 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
161.32 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
161.33 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
161.34 the current statutory rates. Mental health services within diagnosis related groups 424 to
161.35 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded

162.1 from this paragraph. Payments made to managed care plans shall be reduced for services
162.2 provided on or after January 1, 2006, to reflect this reduction.

162.3 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
162.4 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
162.5 to hospitals for inpatient services before third-party liability and spenddown, is reduced
162.6 3.46 percent from the current statutory rates. Mental health services with diagnosis related
162.7 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision
162.8 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced
162.9 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this
162.10 reduction.

162.11 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
162.12 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
162.13 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9
162.14 percent from the current statutory rates. Mental health services with diagnosis related groups
162.15 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are
162.16 excluded from this paragraph. Payments made to managed care plans shall be reduced for
162.17 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

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

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

162.31 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment
162.32 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
162.33 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from
162.34 the current statutory rates. Facilities defined under subdivision 16 are excluded from this

163.1 paragraph. Payments made to managed care plans shall be reduced for services provided
163.2 on or after January 1, 2011, to reflect this reduction.

163.3 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under
163.4 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision
163.5 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),
163.6 and must not be applied to each claim.

163.7 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under
163.8 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
163.9 must be incorporated into the rates and must not be applied to each claim.

163.10 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under
163.11 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be
163.12 incorporated into the rates and must not be applied to each claim.

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

163.14 Sec. 11. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

163.15 Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day
163.16 outlier thresholds for each diagnostic category established under subdivision 2 at two standard
163.17 deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold
163.18 shall be in addition to the operating and property payment rates per admission established
163.19 under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable
163.20 operating cost, after adjustment by the case mix index, hospital cost index, relative values
163.21 and the disproportionate population adjustment. The outlier threshold for neonatal and burn
163.22 diagnostic categories shall be established at one standard deviation beyond the mean length
163.23 of stay, and payment shall be at 90 percent of allowable operating cost calculated in the
163.24 same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier
163.25 payment that is at a minimum of 60 percent and a maximum of 80 percent if the
163.26 commissioner is notified in writing of the request by October 1 of the year preceding the
163.27 rate year. The chosen percentage applies to all diagnostic categories except burns and
163.28 neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall
163.29 be added back to the base year operating payment rate per admission.

163.30 (b) Effective for admissions and transfers occurring on and after November 1, 2014, the
163.31 commissioner shall establish payment rates for outlier payments that are based on Medicare
163.32 methodologies.

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

164.1 Sec. 12. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:

164.2 Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1,
164.3 2014, payments for hospital residents shall be made as follows:

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

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

164.9 (b) For discharges occurring on or after July 1, 2017, payment for hospital residents
164.10 shall be equal to the payments under subdivision 8, paragraph (b).

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

164.12 Sec. 13. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:

164.13 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions
164.14 occurring on or after July 1, 1993, the medical assistance disproportionate population
164.15 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional
164.16 treatment centers and facilities of the federal Indian Health Service, with a medical assistance
164.17 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined
164.18 as follows:

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

164.26 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
164.27 deviation above the mean, the adjustment must be determined by multiplying the adjustment
164.28 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
164.29 report annually on the number of hospitals likely to receive the adjustment authorized by
164.30 this paragraph. The commissioner shall specifically report on the adjustments received by
164.31 public hospitals and public hospital corporations located in cities of the first class.

165.1 (b) Certified public expenditures made by Hennepin County Medical Center shall be
165.2 considered Medicaid disproportionate share hospital payments. Hennepin County and
165.3 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning
165.4 July 1, 2005, or another date specified by the commissioner, that may qualify for
165.5 reimbursement under federal law. Based on these reports, the commissioner shall apply for
165.6 federal matching funds.

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

165.10 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid
165.11 in accordance with a new methodology using 2012 as the base year. Annual payments made
165.12 under this paragraph shall equal the total amount of payments made for 2012. A licensed
165.13 children's hospital shall receive only a single DSH factor for children's hospitals. Other
165.14 DSH factors may be combined to arrive at a single factor for each hospital that is eligible
165.15 for DSH payments. The new methodology shall make payments only to hospitals located
165.16 in Minnesota and include the following factors:

165.17 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the
165.18 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000
165.19 fee-for-service discharges in the base year shall receive a factor of 0.7880;

165.20 (2) a hospital that has in effect for the initial rate year a contract with the commissioner
165.21 to provide extended psychiatric inpatient services under section 256.9693 shall receive a
165.22 factor of 0.0160;

165.23 (3) a hospital that has received payment from the fee-for-service program for at least 20
165.24 transplant services in the base year shall receive a factor of 0.0435;

165.25 (4) a hospital that has a medical assistance utilization rate in the base year between 20
165.26 percent up to one standard deviation above the statewide mean utilization rate shall receive
165.27 a factor of 0.0468;

165.28 (5) a hospital that has a medical assistance utilization rate in the base year that is at least
165.29 one standard deviation above the statewide mean utilization rate but is less than three standard
165.30 deviations above the mean shall receive a factor of 0.2300; and

165.31 (6) a hospital that has a medical assistance utilization rate in the base year that is at least
165.32 three standard deviations above the statewide mean utilization rate shall receive a factor of
165.33 0.3711.

166.1 (e) Any payments or portion of payments made to a hospital under this subdivision that
166.2 are subsequently returned to the commissioner because the payments are found to exceed
166.3 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the
166.4 number of fee-for-service discharges, to other DSH-eligible ~~nonchildren's~~ non-children's
166.5 hospitals that have a medical assistance utilization rate that is at least one standard deviation
166.6 above the mean.

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

166.8 Sec. 14. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

166.9 Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are
166.10 recognized as rehabilitation distinct parts by the Medicare program shall have separate
166.11 provider numbers under the medical assistance program for rate establishment and billing
166.12 purposes only. These units shall also have operating payment rates and the disproportionate
166.13 population adjustment, if allowed by federal law, established separately from other inpatient
166.14 hospital services.

166.15 (b) The commissioner shall establish separate relative values under subdivision 2 for
166.16 rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for
166.17 discharges occurring on and after November 1, 2014, the commissioner, to the extent
166.18 possible, shall replicate the existing payment rate methodology under the new diagnostic
166.19 classification system. The result must be budget neutral, ensuring that the total aggregate
166.20 payments under the new system are equal to the total aggregate payments made for the same
166.21 number and types of services in the base year, calendar year 2012.

166.22 (c) For individual hospitals that did not have separate medical assistance rehabilitation
166.23 provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the
166.24 information needed to separate rehabilitation distinct part cost and claims data from other
166.25 inpatient service data.

166.26 (d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals
166.27 shall be established under subdivision 2b, paragraph (a), clause (4).

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

166.29 Sec. 15. Minnesota Statutes 2016, section 256.9695, subdivision 1, is amended to read:

166.30 Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application
166.31 of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would
166.32 result in a change to the hospital's payment rate or payments. Both overpayments and

167.1 underpayments that result from the submission of appeals shall be implemented. Regardless
167.2 of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge
167.3 ratios, and policy adjusters shall not be ~~reallocated~~ changed. The appeal shall be heard by
167.4 an administrative law judge according to sections 14.57 to 14.62, or upon agreement by
167.5 both parties, according to a modified appeals procedure established by the commissioner
167.6 and the Office of Administrative Hearings. In any proceeding under this section, the appealing
167.7 party must demonstrate by a preponderance of the evidence that the commissioner's
167.8 determination is incorrect or not according to law.

167.9 (a) To appeal a payment rate or payment determination or a determination made from
167.10 base year information, the hospital shall file a written appeal request to the commissioner
167.11 within 60 days of the date the preliminary payment rate determination was mailed. The
167.12 appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute
167.13 or rule upon which the hospital relies for each disputed item; and (iii) the name and address
167.14 of the person to contact regarding the appeal. Facts to be considered in any appeal of base
167.15 year information are limited to those in existence ~~at the time the payment rates of the first~~
167.16 ~~rate year were established from the base year information. In the case of Medicare settled~~
167.17 ~~appeals, the 60-day appeal period shall begin on the mailing date of the notice by the~~
167.18 ~~Medicare program or the date the medical assistance payment rate determination notice is~~
167.19 ~~mailed, whichever is later~~ 12 months after the last day of the calendar year that is the base
167.20 year for the payment rates in dispute.

167.21 (b) ~~To appeal a payment rate or payment change that results from a difference in case~~
167.22 ~~mix between the base year and a rate year, the procedures and requirements of paragraph~~
167.23 ~~(a) apply. However, the appeal must be filed with the commissioner within 120 days after~~
167.24 ~~the end of a rate year. A case mix appeal must apply to the cost of services to all medical~~
167.25 ~~assistance patients that received inpatient services from the hospital during the rate year~~
167.26 ~~appealed. For case mix appeals filed after January 1, 1997, the difference in case mix and~~
167.27 ~~the corresponding payment adjustment must exceed a threshold of five percent.~~

167.28 Sec. 16. Minnesota Statutes 2016, section 256B.04, subdivision 12, is amended to read:

167.29 Subd. 12. **Limitation on services.** (a) Place limits on the types of services covered by
167.30 medical assistance, the frequency with which the same or similar services may be covered
167.31 by medical assistance for an individual recipient, and the amount paid for each covered
167.32 service. The state agency shall promulgate rules establishing maximum reimbursement rates
167.33 for emergency and nonemergency transportation.

167.34 The rules shall provide:

168.1 (1) an opportunity for all recognized transportation providers to be reimbursed for
 168.2 nonemergency transportation consistent with the maximum rates established by the agency;
 168.3 and

168.4 (2) reimbursement of public and private nonprofit providers serving the disabled
 168.5 population generally at reasonable maximum rates that reflect the cost of providing the
 168.6 service regardless of the fare that might be charged by the provider for similar services to
 168.7 individuals other than those receiving medical assistance or medical care under this chapter;
 168.8 and.

168.9 ~~(3) reimbursement for each additional passenger carried on a single trip at a substantially~~
 168.10 ~~lower rate than the first passenger carried on that trip.~~

168.11 (b) The commissioner shall encourage providers reimbursed under this chapter to
 168.12 coordinate their operation with similar services that are operating in the same community.
 168.13 To the extent practicable, the commissioner shall encourage eligible individuals to utilize
 168.14 less expensive providers capable of serving their needs.

168.15 (c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective
 168.16 on January 1, 1981, "recognized provider of transportation services" means an operator of
 168.17 special transportation service as defined in section 174.29 that has been issued a current
 168.18 certificate of compliance with operating standards of the commissioner of transportation
 168.19 or, if those standards do not apply to the operator, that the agency finds is able to provide
 168.20 the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized
 168.21 transportation provider" includes an operator of special transportation service that the agency
 168.22 finds is able to provide the required transportation in a safe and reliable manner.

168.23 Sec. 17. Minnesota Statutes 2016, section 256B.04, subdivision 24, is amended to read:

168.24 Subd. 24. **Medicaid waiver requests and state plan amendments.** The commissioner
 168.25 shall notify the chairs and ranking minority members of the legislative committees with
 168.26 jurisdiction over medical assistance at least 30 days before submitting a new Medicaid
 168.27 waiver request to the federal government. Prior to submitting any Medicaid waiver request
 168.28 or Medicaid state plan amendment to the federal government for approval, the commissioner
 168.29 shall publish the text of the waiver request or state plan amendment, and a summary of and
 168.30 explanation of the need for the request, on the agency's Web site and provide a 30-day public
 168.31 comment period. The commissioner shall notify the public of the availability of this
 168.32 information through the agency's electronic subscription service. The commissioner shall
 168.33 consider public comments when preparing the final waiver request or state plan amendment
 168.34 that is to be submitted to the federal government for approval. The commissioner shall also

169.1 publish on the agency's Web site notice of any federal decision related to the state request
169.2 for approval, within 30 days of the decision. This notice must describe any modifications
169.3 to the state request that have been agreed to by the commissioner as a condition of receiving
169.4 federal approval.

169.5 Sec. 18. Minnesota Statutes 2016, section 256B.056, subdivision 3b, is amended to read:

169.6 Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable
169.7 or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a
169.8 person or the person's spouse under the terms of which the person receives or could receive
169.9 payments from the trust principal or income and the trustee has discretion in making payments
169.10 to the person from the trust principal or income. Notwithstanding that definition, a medical
169.11 assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before
169.12 April 7, 1986, solely to benefit a person with a developmental disability living in an
169.13 intermediate care facility for persons with developmental disabilities; or (3) a trust set up
169.14 by a person with payments made by the Social Security Administration pursuant to the
169.15 United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The
169.16 maximum amount of payments that a trustee of a medical assistance qualifying trust may
169.17 make to a person under the terms of the trust is considered to be available assets to the
169.18 person, without regard to whether the trustee actually makes the maximum payments to the
169.19 person and without regard to the purpose for which the medical assistance qualifying trust
169.20 was established.

169.21 (b) ~~Except as provided in paragraphs (c) and (d),~~ Trusts established after August 10,
169.22 1993, are treated according to ~~section 13611(b) of the Omnibus Budget Reconciliation Act~~
169.23 ~~of 1993 (OBRA), Public Law 103-66~~ United States Code, title 42, section 1396p(d).

169.24 (c) For purposes of paragraph (d), a pooled trust means a trust established under United
169.25 States Code, title 42, section 1396p(d)(4)(C).

169.26 (d) A beneficiary's interest in a pooled trust is considered an available asset unless the
169.27 trust provides that upon the death of the beneficiary or termination of the trust during the
169.28 beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the
169.29 amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the
169.30 beneficiary's trust account after a deduction for reasonable administrative fees and expenses,
169.31 and an additional remainder amount. The retained remainder amount of the subaccount
169.32 must not exceed ten percent of the account value at the time of the beneficiary's death or
169.33 termination of the trust, and must only be used for the benefit of disabled individuals who
169.34 have a beneficiary interest in the pooled trust.

170.1 (e) Trusts may be established on or after December 12, 2016, by a person who has been
 170.2 determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A),
 170.3 as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

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

170.5 Sec. 19. Minnesota Statutes 2016, section 256B.056, subdivision 3c, is amended to read:

170.6 Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more
 170.7 persons must not own more than \$20,000 in total net assets, and a household of one person
 170.8 must not own more than \$10,000 in total net assets. In addition to these maximum amounts,
 170.9 an eligible individual or family may accrue interest on these amounts, but they must be
 170.10 reduced to the maximum at the time of an eligibility redetermination. The value of assets
 170.11 that are not considered in determining eligibility for medical assistance for families and
 170.12 children is the value of those assets excluded under the AFDC state plan as of July 16, 1996,
 170.13 as required by the Personal Responsibility and Work Opportunity Reconciliation Act of
 170.14 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

170.16 (2) capital and operating assets of a trade or business up to \$200,000 are not considered;
 170.17 ~~except that a bank account that contains personal income or assets, or is used to pay personal~~
 170.18 ~~expenses, is not considered a capital or operating asset of a trade or business;~~

170.19 (3) one motor vehicle is excluded for each person of legal driving age who is employed
 170.20 or seeking employment;

170.21 (4) assets designated as burial expenses are excluded to the same extent they are excluded
 170.22 by the Supplemental Security Income program;

170.23 (5) court-ordered settlements up to \$10,000 are not considered;

170.24 (6) individual retirement accounts and funds are not considered;

170.25 (7) assets owned by children are not considered; and

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

170.30 ~~The assets specified in clause (2) must be disclosed to the local agency at the time of~~
 170.31 ~~application and at the time of an eligibility redetermination, and must be verified upon~~
 170.32 ~~request of the local agency.~~

171.1 (b) Beginning January 1, 2014, this subdivision applies only to parents and caretaker
171.2 relatives who qualify for medical assistance under subdivision 5.

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

171.4 Sec. 20. Minnesota Statutes 2016, section 256B.056, subdivision 5c, is amended to read:

171.5 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and
171.6 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard
171.7 specified in subdivision 4, paragraph (b).

171.8 (b) The excess income standard for a person whose eligibility is based on blindness,
171.9 disability, or age of 65 or more years shall equal ~~80~~81 percent of the federal poverty
171.10 guidelines.

171.11 **EFFECTIVE DATE.** This section is effective June 1, 2019.

171.12 Sec. 21. Minnesota Statutes 2016, section 256B.0561, subdivision 2, is amended to read:

171.13 Subd. 2. **Periodic data matching.** (a) Beginning ~~March 1, 2016~~ April 1, 2018, the
171.14 commissioner shall conduct periodic data matching to identify recipients who, based on
171.15 available electronic data, may not meet eligibility criteria for the public health care program
171.16 in which the recipient is enrolled. The commissioner shall conduct data matching for medical
171.17 assistance or MinnesotaCare recipients at least once during a recipient's 12-month period
171.18 of eligibility.

171.19 (b) If data matching indicates a recipient may no longer qualify for medical assistance
171.20 or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no
171.21 more than 30 days to confirm the information obtained through the periodic data matching
171.22 or provide a reasonable explanation for the discrepancy to the state or county agency directly
171.23 responsible for the recipient's case. If a recipient does not respond within the advance notice
171.24 period or does not respond with information that demonstrates eligibility or provides a
171.25 reasonable explanation for the discrepancy within the 30-day time period, the commissioner
171.26 shall terminate the recipient's eligibility in the manner provided for by the laws and
171.27 regulations governing the health care program for which the recipient has been identified
171.28 as being ineligible.

171.29 (c) The commissioner shall not terminate eligibility for a recipient who is cooperating
171.30 with the requirements of paragraph (b) and needs additional time to provide information in
171.31 response to the notification.

172.1 (d) Any termination of eligibility for benefits under this section may be appealed as
172.2 provided for in sections 256.045 to 256.0451, and the laws governing the health care
172.3 programs for which eligibility is terminated.

172.4 Sec. 22. Minnesota Statutes 2016, section 256B.0561, subdivision 4, is amended to read:

172.5 Subd. 4. **Report.** By September 1, ~~2017~~ 2018, and each September 1 thereafter, the
172.6 commissioner shall submit a report to the chairs and ranking minority members of the house
172.7 and senate committees with jurisdiction over human services finance that includes the
172.8 number of cases affected by periodic data matching under this section, the number of
172.9 recipients identified as possibly ineligible as a result of a periodic data match, and the number
172.10 of recipients whose eligibility was terminated as a result of a periodic data match. The report
172.11 must also specify, for recipients whose eligibility was terminated, how many cases were
172.12 closed due to failure to cooperate.

172.13 Sec. 23. Minnesota Statutes 2016, section 256B.057, subdivision 9, as amended by Laws
172.14 2017, chapter 59, section 9, is amended to read:

172.15 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for
172.16 a person who is employed and who:

172.17 (1) but for excess earnings or assets, meets the definition of disabled under the
172.18 Supplemental Security Income program;

172.19 (2) meets the asset limits in paragraph (d); and

172.20 (3) pays a premium and other obligations under paragraph (e).

172.21 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
172.22 for medical assistance under this subdivision, a person must have more than \$65 of earned
172.23 income. Earned income must have Medicare, Social Security, and applicable state and
172.24 federal taxes withheld. The person must document earned income tax withholding. Any
172.25 spousal income or assets shall be disregarded for purposes of eligibility and premium
172.26 determinations.

172.27 (c) After the month of enrollment, a person enrolled in medical assistance under this
172.28 subdivision who:

172.29 (1) is temporarily unable to work and without receipt of earned income due to a medical
172.30 condition, as verified by a physician, advanced practice registered nurse, or physician
172.31 assistant; or

173.1 (2) loses employment for reasons not attributable to the enrollee, and is without receipt
173.2 of earned income may retain eligibility for up to four consecutive months after the month
173.3 of job loss. To receive a four-month extension, enrollees must verify the medical condition
173.4 or provide notification of job loss. All other eligibility requirements must be met and the
173.5 enrollee must pay all calculated premium costs for continued eligibility.

173.6 (d) For purposes of determining eligibility under this subdivision, a person's assets must
173.7 not exceed \$20,000, excluding:

173.8 (1) all assets excluded under section 256B.056;

173.9 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh
173.10 plans, and pension plans;

173.11 (3) medical expense accounts set up through the person's employer; and

173.12 (4) spousal assets, including spouse's share of jointly held assets.

173.13 (e) All enrollees must pay a premium to be eligible for medical assistance under this
173.14 subdivision, except as provided under clause (5).

173.15 (1) An enrollee must pay the greater of a \$35 premium or the premium calculated based
173.16 on the person's gross earned and unearned income and the applicable family size using a
173.17 sliding fee scale established by the commissioner, which begins at one percent of income
173.18 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for
173.19 those with incomes at or above 300 percent of the federal poverty guidelines.

173.20 (2) Annual adjustments in the premium schedule based upon changes in the federal
173.21 poverty guidelines shall be effective for premiums due in July of each year.

173.22 (3) All enrollees who receive unearned income must pay one-half of one percent of
173.23 unearned income in addition to the premium amount, except as provided under clause (5).

173.24 (4) Increases in benefits under title II of the Social Security Act shall not be counted as
173.25 income for purposes of this subdivision until July 1 of each year.

173.26 (5) Effective July 1, 2009, American Indians are exempt from paying premiums as
173.27 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
173.28 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
173.29 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

173.30 (f) A person's eligibility and premium shall be determined by the local county agency.
173.31 Premiums must be paid to the commissioner. All premiums are dedicated to the
173.32 commissioner.

174.1 (g) Any required premium shall be determined at application and redetermined at the
 174.2 enrollee's six-month income review or when a change in income or household size is reported.
 174.3 Enrollees must report any change in income or household size within ten days of when the
 174.4 change occurs. A decreased premium resulting from a reported change in income or
 174.5 household size shall be effective the first day of the next available billing month after the
 174.6 change is reported. Except for changes occurring from annual cost-of-living increases, a
 174.7 change resulting in an increased premium shall not affect the premium amount until the
 174.8 next six-month review.

174.9 (h) Premium payment is due upon notification from the commissioner of the premium
 174.10 amount required. Premiums may be paid in installments at the discretion of the commissioner.

174.11 (i) Nonpayment of the premium shall result in denial or termination of medical assistance
 174.12 unless the person demonstrates good cause for nonpayment. ~~Good cause exists if the~~
 174.13 ~~requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are~~
 174.14 ~~met~~ "Good cause" means an excuse for the enrollee's failure to pay the required premium
 174.15 when due because the circumstances were beyond the enrollee's control or not reasonably
 174.16 foreseeable. The commissioner shall determine whether good cause exists based on the
 174.17 weight of the supporting evidence submitted by the enrollee to demonstrate good cause.
 174.18 Except when an installment agreement is accepted by the commissioner, all persons
 174.19 disenrolled for nonpayment of a premium must pay any past due premiums as well as current
 174.20 premiums due prior to being reenrolled. Nonpayment shall include payment with a returned,
 174.21 refused, or dishonored instrument. The commissioner may require a guaranteed form of
 174.22 payment as the only means to replace a returned, refused, or dishonored instrument.

174.23 (j) For enrollees whose income does not exceed 200 percent of the federal poverty
 174.24 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the
 174.25 enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph
 174.26 (a).

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

174.28 Sec. 24. Minnesota Statutes 2016, section 256B.059, subdivision 6, as amended by Laws
 174.29 2017, chapter 40, article 1, section 66, is amended to read:

174.30 Subd. 6. **Temporary application.** (a) During the period in which rules against spousal
 174.31 impoverishment are temporarily applied according to section 2404 of the Patient Protection
 174.32 Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education
 174.33 Reconciliation Act of 2010, Public Law 111-152, this section applies to an institutionalized
 174.34 spouse:

175.1 (1) applying for home and community-based waivers under sections 256B.092, 256B.093,
175.2 and 256B.49 on or after June 1, 2016;

175.3 (2) enrolled in home and community-based waivers under sections 256B.092, 256B.093,
175.4 and 256B.49 before June 1, 2016, based on an application submitted on or after January 1,
175.5 2014; or

175.6 (3) applying for services under section 256B.85 upon the effective date of that section.

175.7 (b) During the applicable period of paragraph (a), the definition of "institutionalized
175.8 spouse" in subdivision 1, paragraph (e), also includes an institutionalized spouse referenced
175.9 in paragraph (a).

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

175.11 Sec. 25. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

175.12 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case
175.13 management under this subdivision. Case managers may bill according to the following
175.14 criteria:

175.15 (1) for relocation targeted case management, case managers may bill for direct case
175.16 management activities, including face-to-face ~~and contact~~, telephone ~~contacts~~ contact, and
175.17 interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

175.18 (i) 180 days preceding an eligible recipient's discharge from an institution; or

175.19 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

175.20 (2) for home care targeted case management, case managers may bill for direct case
175.21 management activities, including face-to-face and telephone contacts; and

175.22 (3) billings for targeted case management services under this subdivision shall not
175.23 duplicate payments made under other program authorities for the same purpose.

175.24 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
175.25 of human services shall notify the revisor of statutes when federal approval is obtained.

175.26 Sec. 26. Minnesota Statutes 2016, section 256B.0625, subdivision 1, is amended to read:

175.27 Subdivision 1. **Inpatient hospital services.** (a) Medical assistance covers inpatient
175.28 hospital services. A second medical opinion is required prior to reimbursement for elective
175.29 surgeries requiring a second opinion. The commissioner shall publish in the State Register
175.30 a list of elective surgeries that require a second medical opinion prior to reimbursement,

176.1 and the criteria and standards for deciding whether an elective surgery should require a
176.2 second medical opinion. The list and the criteria and standards are not subject to the
176.3 requirements of sections 14.001 to 14.69. The commissioner's decision whether a second
176.4 medical opinion is required, made in accordance with rules governing that decision, is not
176.5 subject to administrative appeal.

176.6 (b) When determining medical necessity for inpatient hospital services, the medical
176.7 review agent shall follow industry standard medical necessity criteria in determining the
176.8 following:

176.9 (1) whether a recipient's admission is medically necessary;

176.10 (2) whether the inpatient hospital services provided to the recipient were medically
176.11 necessary;

176.12 (3) whether the recipient's continued stay was or will be medically necessary; and

176.13 (4) whether all medically necessary inpatient hospital services were provided to the
176.14 recipient.

176.15 The medical review agent will determine medical necessity of inpatient hospital services,
176.16 including inpatient psychiatric treatment, based on a review of the patient's medical condition
176.17 and records, in conjunction with industry standard evidence-based criteria to ensure consistent
176.18 and optimal application of medical appropriateness criteria.

176.19 Sec. 27. Minnesota Statutes 2016, section 256B.0625, subdivision 3b, is amended to read:

176.20 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
176.21 services and consultations delivered by a licensed health care provider via telemedicine in
176.22 the same manner as if the service or consultation was delivered in person. Coverage is
176.23 limited to three telemedicine services per enrollee per calendar week. Telemedicine services
176.24 shall be paid at the full allowable rate.

176.25 (b) The commissioner shall establish criteria that a health care provider must attest to
176.26 in order to demonstrate the safety or efficacy of delivering a particular service via
176.27 telemedicine. The attestation may include that the health care provider:

176.28 (1) has identified the categories or types of services the health care provider will provide
176.29 via telemedicine;

176.30 (2) has written policies and procedures specific to telemedicine services that are regularly
176.31 reviewed and updated;

177.1 (3) has policies and procedures that adequately address patient safety before, during,
177.2 and after the telemedicine service is rendered;

177.3 (4) has established protocols addressing how and when to discontinue telemedicine
177.4 services; and

177.5 (5) has an established quality assurance process related to telemedicine services.

177.6 (c) As a condition of payment, a licensed health care provider must document each
177.7 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
177.8 Health care service records for services provided by telemedicine must meet the requirements
177.9 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

177.10 (1) the type of service provided by telemedicine;

177.11 (2) the time the service began and the time the service ended, including an a.m. and p.m.
177.12 designation;

177.13 (3) the licensed health care provider's basis for determining that telemedicine is an
177.14 appropriate and effective means for delivering the service to the enrollee;

177.15 (4) the mode of transmission of the telemedicine service and records evidencing that a
177.16 particular mode of transmission was utilized;

177.17 (5) the location of the originating site and the distant site;

177.18 (6) if the claim for payment is based on a physician's telemedicine consultation with
177.19 another physician, the written opinion from the consulting physician providing the
177.20 telemedicine consultation; and

177.21 (7) compliance with the criteria attested to by the health care provider in accordance
177.22 with paragraph (b).

177.23 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
177.24 "telemedicine" is defined as the delivery of health care services or consultations while the
177.25 patient is at an originating site and the licensed health care provider is at a distant site. A
177.26 communication between licensed health care providers, or a licensed health care provider
177.27 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
177.28 does not constitute telemedicine consultations or services. Telemedicine may be provided
177.29 by means of real-time two-way, interactive audio and visual communications, including the
177.30 application of secure video conferencing or store-and-forward technology to provide or
177.31 support health care delivery, which facilitate the assessment, diagnosis, consultation,
177.32 treatment, education, and care management of a patient's health care.

178.1 (e) For purposes of this section, "licensed health care provider" ~~is defined~~ means a
 178.2 licensed health care provider under section 62A.671, subdivision 6, and a mental health
 178.3 practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26,
 178.4 working under the general supervision of a mental health professional; "health care provider"
 178.5 is defined under section 62A.671, subdivision 3; and "originating site" is defined under
 178.6 section 62A.671, subdivision 7.

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

178.8 Sec. 28. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

178.9 Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in
 178.10 a recipient's home. Recipients who are authorized to receive home care nursing services in
 178.11 their home may use approved hours outside of the home during hours when normal life
 178.12 activities take them outside of their home. To use home care nursing services at school, the
 178.13 recipient or responsible party must provide written authorization in the care plan identifying
 178.14 the chosen provider and the daily amount of services to be used at school. Medical assistance
 178.15 does not cover home care nursing services for residents of a hospital, nursing facility,
 178.16 intermediate care facility, or a health care facility licensed by the commissioner of health,
 178.17 ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~
 178.18 ~~unless a resident who is otherwise eligible is on leave from the facility and the facility either~~
 178.19 ~~pays for the home care nursing services or forgoes the facility per diem for the leave days~~
 178.20 ~~that home care nursing services are used. Total hours of service and payment allowed for~~
 178.21 ~~services outside the home cannot exceed that which is otherwise allowed in an in-home~~
 178.22 ~~setting according to sections 256B.0651 and 256B.0654 . All home care nursing services~~
 178.23 ~~must be provided according to the limits established under sections 256B.0651, 256B.0653,~~
 178.24 ~~and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family~~
 178.25 ~~foster care provider of a recipient who is under age 18, unless allowed under section~~
 178.26 ~~256B.0654, subdivision 4.~~

178.27 Sec. 29. Minnesota Statutes 2016, section 256B.0625, subdivision 17, is amended to read:

178.28 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
 178.29 means motor vehicle transportation provided by a public or private person that serves
 178.30 Minnesota health care program beneficiaries who do not require emergency ambulance
 178.31 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

178.32 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
 178.33 emergency medical care or transportation costs incurred by eligible persons in obtaining

179.1 emergency or nonemergency medical care when paid directly to an ambulance company,
179.2 ~~common carrier~~ nonemergency medical transportation company, or other recognized
179.3 providers of transportation services. Medical transportation must be provided by:

179.4 (1) nonemergency medical transportation providers who meet the requirements of this
179.5 subdivision;

179.6 (2) ambulances, as defined in section 144E.001, subdivision 2;

179.7 (3) taxicabs that meet the requirements of this subdivision;

179.8 (4) public transit, as defined in section 174.22, subdivision 7; or

179.9 (5) not-for-hire vehicles, including volunteer drivers.

179.10 (c) Medical assistance covers nonemergency medical transportation provided by
179.11 nonemergency medical transportation providers enrolled in the Minnesota health care
179.12 programs. All nonemergency medical transportation providers must comply with the
179.13 operating standards for special transportation service as defined in sections 174.29 to 174.30
179.14 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of
179.15 Transportation. All nonemergency medical transportation providers shall bill for
179.16 nonemergency medical transportation services in accordance with Minnesota health care
179.17 programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles
179.18 are exempt from the requirements outlined in this paragraph.

179.19 (d) An organization may be terminated, denied, or suspended from enrollment if:

179.20 (1) the provider has not initiated background studies on the individuals specified in
179.21 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

179.22 (2) the provider has initiated background studies on the individuals specified in section
179.23 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

179.24 (i) the commissioner has sent the provider a notice that the individual has been
179.25 disqualified under section 245C.14; and

179.26 (ii) the individual has not received a disqualification set-aside specific to the special
179.27 transportation services provider under sections 245C.22 and 245C.23.

179.28 (e) The administrative agency of nonemergency medical transportation must:

179.29 (1) adhere to the policies defined by the commissioner in consultation with the
179.30 Nonemergency Medical Transportation Advisory Committee;

180.1 (2) pay nonemergency medical transportation providers for services provided to
180.2 Minnesota health care programs beneficiaries to obtain covered medical services;

180.3 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
180.4 trips, and number of trips by mode; and

180.5 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single
180.6 administrative structure assessment tool that meets the technical requirements established
180.7 by the commissioner, reconciles trip information with claims being submitted by providers,
180.8 and ensures prompt payment for nonemergency medical transportation services.

180.9 (f) Until the commissioner implements the single administrative structure and delivery
180.10 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
180.11 commissioner or an entity approved by the commissioner that does not dispatch rides for
180.12 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

180.13 (g) The commissioner may use an order by the recipient's attending physician or a medical
180.14 or mental health professional to certify that the recipient requires nonemergency medical
180.15 transportation services. Nonemergency medical transportation providers shall perform
180.16 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
180.17 includes passenger pickup at and return to the individual's residence or place of business,
180.18 assistance with admittance of the individual to the medical facility, and assistance in
180.19 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

180.20 Nonemergency medical transportation providers must take clients to the health care
180.21 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
180.22 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
180.23 authorization from the local agency.

180.24 Nonemergency medical transportation providers may not bill for separate base rates for
180.25 the continuation of a trip beyond the original destination. Nonemergency medical
180.26 transportation providers must maintain trip logs, which include pickup and drop-off times,
180.27 signed by the medical provider or client, whichever is deemed most appropriate, attesting
180.28 to mileage traveled to obtain covered medical services. Clients requesting client mileage
180.29 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
180.30 services.

180.31 (h) The administrative agency shall use the level of service process established by the
180.32 commissioner in consultation with the Nonemergency Medical Transportation Advisory
180.33 Committee to determine the client's most appropriate mode of transportation. If public transit

181.1 or a certified transportation provider is not available to provide the appropriate service mode
181.2 for the client, the client may receive a onetime service upgrade.

181.3 (i) The covered modes of transportation, ~~which may not be implemented without a new~~
181.4 ~~rate structure~~, are:

181.5 (1) client reimbursement, which includes client mileage reimbursement provided to
181.6 clients who have their own transportation, or to family or an acquaintance who provides
181.7 transportation to the client;

181.8 (2) volunteer transport, which includes transportation by volunteers using their own
181.9 vehicle;

181.10 (3) unassisted transport, which includes transportation provided to a client by a taxicab
181.11 or public transit. If a taxicab or public transit is not available, the client can receive
181.12 transportation from another nonemergency medical transportation provider;

181.13 (4) assisted transport, which includes transport provided to clients who require assistance
181.14 by a nonemergency medical transportation provider;

181.15 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
181.16 dependent on a device and requires a nonemergency medical transportation provider with
181.17 a vehicle containing a lift or ramp;

181.18 (6) protected transport, which includes transport provided to a client who has received
181.19 a prescreening that has deemed other forms of transportation inappropriate and who requires
181.20 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
181.21 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
181.22 the vehicle driver; and (ii) who is certified as a protected transport provider; and

181.23 (7) stretcher transport, which includes transport for a client in a prone or supine position
181.24 and requires a nonemergency medical transportation provider with a vehicle that can transport
181.25 a client in a prone or supine position.

181.26 (j) The local agency shall be the single administrative agency and shall administer and
181.27 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
181.28 commissioner has developed, made available, and funded the Web-based single
181.29 administrative structure, assessment tool, and level of need assessment under subdivision
181.30 18e. The local agency's financial obligation is limited to funds provided by the state or
181.31 federal government.

181.32 (k) The commissioner shall:

182.1 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
182.2 verify that the mode and use of nonemergency medical transportation is appropriate;

182.3 (2) verify that the client is going to an approved medical appointment; and

182.4 (3) investigate all complaints and appeals.

182.5 (l) The administrative agency shall pay for the services provided in this subdivision and
182.6 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
182.7 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
182.8 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

182.9 (m) Payments for nonemergency medical transportation must be paid based on the client's
182.10 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
182.11 medical assistance reimbursement rates for nonemergency medical transportation services
182.12 that are payable by or on behalf of the commissioner for nonemergency medical
182.13 transportation services are:

182.14 (1) \$0.22 per mile for client reimbursement;

182.15 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
182.16 transport;

182.17 (3) equivalent to the standard fare for unassisted transport when provided by public
182.18 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
182.19 medical transportation provider;

182.20 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

182.21 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

182.22 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

182.23 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
182.24 an additional attendant if deemed medically necessary.

182.25 (n) The base rate for nonemergency medical transportation services in areas defined
182.26 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
182.27 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
182.28 services in areas defined under RUCA to be rural or super rural areas is:

182.29 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
182.30 rate in paragraph (m), clauses (1) to (7); and

183.1 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
183.2 rate in paragraph (m), clauses (1) to (7).

183.3 (o) For purposes of reimbursement rates for nonemergency medical transportation
183.4 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
183.5 shall determine whether the urban, rural, or super rural reimbursement rate applies.

183.6 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
183.7 a census-tract based classification system under which a geographical area is determined
183.8 to be urban, rural, or super rural.

183.9 (q) The commissioner, when determining reimbursement rates for nonemergency medical
183.10 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
183.11 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

183.12 Sec. 30. Minnesota Statutes 2016, section 256B.0625, subdivision 17b, is amended to
183.13 read:

183.14 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency
183.15 medical transportation providers must document each occurrence of a service provided to
183.16 a recipient according to this subdivision. Providers must maintain odometer and other records
183.17 sufficient to distinguish individual trips with specific vehicles and drivers. The documentation
183.18 may be collected and maintained using electronic systems or software or in paper form but
183.19 must be made available and produced upon request. Program funds paid for transportation
183.20 that is not documented according to this subdivision shall be recovered by the department.

183.21 (b) A nonemergency medical transportation provider must compile transportation records
183.22 that meet the following requirements:

183.23 (1) the record must be in English and must be legible according to the standard of a
183.24 reasonable person;

183.25 (2) the recipient's name must be on each page of the record; and

183.26 (3) each entry in the record must document:

183.27 (i) the date on which the entry is made;

183.28 (ii) the date or dates the service is provided;

183.29 (iii) the printed last name, first name, and middle initial of the driver;

183.30 (iv) the signature of the driver attesting to the following: "I certify that I have accurately
183.31 reported in this record the trip miles I actually drove and the dates and times I actually drove

184.1 them. I understand that misreporting the miles driven and hours worked is fraud for which
 184.2 I could face criminal prosecution or civil proceedings.";

184.3 (v) the signature of the recipient or authorized party attesting to the following: "I certify
 184.4 that I received the reported transportation service.", or the signature of the provider of
 184.5 medical services certifying that the recipient was delivered to the provider;

184.6 (vi) the address, or the description if the address is not available, of both the origin and
 184.7 destination, and the mileage for the most direct route from the origin to the destination;

184.8 (vii) the mode of transportation in which the service is provided;

184.9 (viii) the license plate number of the vehicle used to transport the recipient;

184.10 (ix) whether the service was ambulatory or nonambulatory ~~until the modes under~~
 184.11 ~~subdivision 17 are implemented;~~

184.12 (x) the time of the pickup and the time of the drop-off with "a.m." and "p.m."
 184.13 designations;

184.14 (xi) the name of the extra attendant when an extra attendant is used to provide special
 184.15 transportation service; and

184.16 (xii) the electronic source documentation used to calculate driving directions and mileage.

184.17 Sec. 31. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
 184.18 to read:

184.19 Subd. 17c. **Nursing facility transports.** A Minnesota health care program enrollee
 184.20 residing in, or being discharged from, a licensed nursing facility is exempt from a level of
 184.21 need determination and is eligible for nonemergency medical transportation services until
 184.22 the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04,
 184.23 subdivision 14a.

184.24 Sec. 32. Minnesota Statutes 2016, section 256B.0625, subdivision 18h, is amended to
 184.25 read:

184.26 Subd. 18h. **Managed care.** (a) The following subdivisions ~~do not~~ apply to managed
 184.27 care plans and county-based purchasing plans:

184.28 (1) subdivision 17, paragraphs ~~(d) to (k)~~ (a), (b), (i), and (n);

184.29 (2) subdivision ~~18e~~ 18; and

184.30 (3) subdivision ~~18g~~ 18a.

185.1 (b) A nonemergency medical transportation provider must comply with the operating
185.2 standards for special transportation service specified in sections 174.29 to 174.30 and
185.3 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire
185.4 vehicles are exempt from the requirements in this paragraph.

185.5 Sec. 33. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

185.6 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
185.7 state agency, medical assistance covers case management services to persons with serious
185.8 and persistent mental illness and children with severe emotional disturbance. Services
185.9 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
185.10 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
185.11 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

185.12 (b) Entities meeting program standards set out in rules governing family community
185.13 support services as defined in section 245.4871, subdivision 17, are eligible for medical
185.14 assistance reimbursement for case management services for children with severe emotional
185.15 disturbance when these services meet the program standards in Minnesota Rules, parts
185.16 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

185.17 (c) Medical assistance and MinnesotaCare payment for mental health case management
185.18 shall be made on a monthly basis. In order to receive payment for an eligible child, the
185.19 provider must document at least a face-to-face contact with the child, the child's parents, or
185.20 the child's legal representative. To receive payment for an eligible adult, the provider must
185.21 document:

185.22 (1) at least a face-to-face contact with the adult or the adult's legal representative or a
185.23 contact by interactive video that meets the requirements of subdivision 20b; or

185.24 (2) at least a telephone contact with the adult or the adult's legal representative and
185.25 document a face-to-face contact or a contact by interactive video that meets the requirements
185.26 of subdivision 20b with the adult or the adult's legal representative within the preceding
185.27 two months.

185.28 (d) Payment for mental health case management provided by county or state staff shall
185.29 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
185.30 (b), with separate rates calculated for child welfare and mental health, and within mental
185.31 health, separate rates for children and adults.

186.1 (e) Payment for mental health case management provided by Indian health services or
186.2 by agencies operated by Indian tribes may be made according to this section or other relevant
186.3 federally approved rate setting methodology.

186.4 (f) Payment for mental health case management provided by vendors who contract with
186.5 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or
186.6 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
186.7 service to other payers. If the service is provided by a team of contracted vendors, the county
186.8 or tribe may negotiate a team rate with a vendor who is a member of the team. The team
186.9 shall determine how to distribute the rate among its members. No reimbursement received
186.10 by contracted vendors shall be returned to the county or tribe, except to reimburse the county
186.11 or tribe for advance funding provided by the county or tribe to the vendor.

186.12 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
186.13 and county or state staff, the costs for county or state staff participation in the team shall be
186.14 included in the rate for county-provided services. In this case, the contracted vendor, the
186.15 tribal agency, and the county may each receive separate payment for services provided by
186.16 each entity in the same month. In order to prevent duplication of services, each entity must
186.17 document, in the recipient's file, the need for team case management and a description of
186.18 the roles of the team members.

186.19 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
186.20 mental health case management shall be provided by the recipient's county of responsibility,
186.21 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
186.22 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
186.23 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
186.24 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
186.25 the recipient's county of responsibility.

186.26 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
186.27 and MinnesotaCare include mental health case management. When the service is provided
186.28 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
186.29 share.

186.30 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
186.31 that does not meet the reporting or other requirements of this section. The county of
186.32 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
186.33 is responsible for any federal disallowances. The county or tribe may share this responsibility
186.34 with its contracted vendors.

187.1 (k) The commissioner shall set aside a portion of the federal funds earned for county
187.2 expenditures under this section to repay the special revenue maximization account under
187.3 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

187.4 (1) the costs of developing and implementing this section; and

187.5 (2) programming the information systems.

187.6 (l) Payments to counties and tribal agencies for case management expenditures under
187.7 this section shall only be made from federal earnings from services provided under this
187.8 section. When this service is paid by the state without a federal share through fee-for-service,
187.9 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
187.10 shall include the federal earnings, the state share, and the county share.

187.11 (m) Case management services under this subdivision do not include therapy, treatment,
187.12 legal, or outreach services.

187.13 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
187.14 and the recipient's institutional care is paid by medical assistance, payment for case
187.15 management services under this subdivision is limited to the lesser of:

187.16 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
187.17 than six months in a calendar year; or

187.18 (2) the limits and conditions which apply to federal Medicaid funding for this service.

187.19 (o) Payment for case management services under this subdivision shall not duplicate
187.20 payments made under other program authorities for the same purpose.

187.21 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
187.22 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
187.23 mental health targeted case management services must actively support identification of
187.24 community alternatives for the recipient and discharge planning.

187.25 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
187.26 of human services shall notify the revisor of statutes when federal approval is obtained.

187.27 Sec. 34. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
187.28 to read:

187.29 Subd. 20b. **Mental health targeted case management through interactive video.** (a)
187.30 Subject to federal approval, contact made for targeted case management by interactive video
187.31 shall be eligible for payment if:

- 188.1 (1) the person receiving targeted case management services is residing in:
- 188.2 (i) a hospital;
- 188.3 (ii) a nursing facility; or
- 188.4 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
- 188.5 establishment or lodging establishment that provides supportive services or health supervision
- 188.6 services according to section 157.17 that is staffed 24 hours a day, seven days a week;
- 188.7 (2) interactive video is in the best interests of the person and is deemed appropriate by
- 188.8 the person receiving targeted case management or the person's legal guardian, the case
- 188.9 management provider, and the provider operating the setting where the person is residing;
- 188.10 (3) the use of interactive video is approved as part of the person's written personal service
- 188.11 or case plan, taking into consideration the person's vulnerability and active personal
- 188.12 relationships; and
- 188.13 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
- 188.14 required face-to-face contact.
- 188.15 (b) The person receiving targeted case management or the person's legal guardian has
- 188.16 the right to choose and consent to the use of interactive video under this subdivision and
- 188.17 has the right to refuse the use of interactive video at any time.
- 188.18 (c) The commissioner shall establish criteria that a targeted case management provider
- 188.19 must attest to in order to demonstrate the safety or efficacy of delivering the service via
- 188.20 interactive video. The attestation may include that the case management provider has:
- 188.21 (1) written policies and procedures specific to interactive video services that are regularly
- 188.22 reviewed and updated;
- 188.23 (2) policies and procedures that adequately address client safety before, during, and after
- 188.24 the interactive video services are rendered;
- 188.25 (3) established protocols addressing how and when to discontinue interactive video
- 188.26 services; and
- 188.27 (4) established a quality assurance process related to interactive video services.
- 188.28 (d) As a condition of payment, the targeted case management provider must document
- 188.29 the following for each occurrence of targeted case management provided by interactive
- 188.30 video:

189.1 (1) the time the service began and the time the service ended, including an a.m. and p.m.
189.2 designation;

189.3 (2) the basis for determining that interactive video is an appropriate and effective means
189.4 for delivering the service to the person receiving case management services;

189.5 (3) the mode of transmission of the interactive video services and records evidencing
189.6 that a particular mode of transmission was utilized;

189.7 (4) the location of the originating site and the distant site; and

189.8 (5) compliance with the criteria attested to by the targeted case management provider
189.9 as provided in paragraph (c).

189.10 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
189.11 of human services shall notify the revisor of statutes when federal approval is obtained.

189.12 Sec. 35. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
189.13 to read:

189.14 **Subd. 31c. Preferred incontinence product program.** The commissioner shall
189.15 implement a preferred incontinence product program by July 1, 2018. The program shall
189.16 require the commissioner to volume purchase incontinence products and related supplies
189.17 in accordance with section 256B.04, subdivision 14. Medical assistance coverage for
189.18 incontinence products and related supplies shall conform to the limitations established under
189.19 the program.

189.20 Sec. 36. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
189.21 to read:

189.22 **Subd. 56a. Post-arrest community-based service coordination.** (a) Medical assistance
189.23 covers post-arrest community-based service coordination for an individual who:

189.24 (1) has been identified as having a mental illness or substance use disorder using a
189.25 screening tool approved by the commissioner;

189.26 (2) does not require the security of a public detention facility and is not considered an
189.27 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
189.28 435.1010;

189.29 (3) meets the eligibility requirements in section 256B.056; and

189.30 (4) has agreed to participate in post-arrest community-based service coordination through
189.31 a diversion contract in lieu of incarceration.

190.1 (b) Post-arrest community-based service coordination means navigating services to
190.2 address a client's mental health, chemical health, social, economic, and housing needs, or
190.3 any other activity targeted at reducing the incidence of jail utilization and connecting
190.4 individuals with existing covered services available to them, including, but not limited to,
190.5 targeted case management, waiver case management, or care coordination.

190.6 (c) Post-arrest community-based service coordination must be provided by an individual
190.7 who is an employee of a county or is under contract with a county to provide post-arrest
190.8 community-based coordination and is qualified under one of the following criteria:

190.9 (1) a licensed mental health professional as defined in section 245.462, subdivision 18,
190.10 clauses (1) to (6);

190.11 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
190.12 under the clinical supervision of a mental health professional; or

190.13 (3) a certified peer specialist under section 256B.0615, working under the clinical
190.14 supervision of a mental health professional.

190.15 (d) Reimbursement is allowed for up to 60 days following the initial determination of
190.16 eligibility.

190.17 (e) Providers of post-arrest community-based service coordination shall annually report
190.18 to the commissioner on the number of individuals served, and number of the
190.19 community-based services that were accessed by recipients. The commissioner shall ensure
190.20 that services and payments provided under post-arrest community-based service coordination
190.21 do not duplicate services or payments provided under section 256B.0625, subdivision 20,
190.22 256B.0753, 256B.0755, or 256B.0757.

190.23 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
190.24 post-arrest community-based service coordination services shall be provided by the recipient's
190.25 county of residence, from sources other than federal funds or funds used to match other
190.26 federal funds.

190.27 **EFFECTIVE DATE.** This section is effective upon federal approval for services
190.28 provided on or after July 1, 2017. The commissioner of human services shall notify the
190.29 revisor of statutes when federal approval is obtained.

190.30 Sec. 37. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

190.31 Subd. 64. **Investigational drugs, biological products, and devices.** (a) Medical
190.32 assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do

191.1 not cover costs incidental to, associated with, or resulting from the use of investigational
191.2 drugs, biological products, or devices as defined in section 151.375.

191.3 (b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program
191.4 if all the following conditions are met:

191.5 (1) the use of stiripentol is determined to be medically necessary;

191.6 (2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether
191.7 an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating
191.8 partial epilepsy in infancy due to an SCN2A genetic mutation;

191.9 (3) all other available covered prescription medications that are medically necessary for
191.10 the enrollee have been tried without successful outcomes; and

191.11 (4) the United States Food and Drug Administration has approved the treating physician's
191.12 individual patient investigational new drug application (IND) for the use of stiripentol for
191.13 treatment.

191.14 This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

191.15 Sec. 38. Minnesota Statutes 2016, section 256B.0644, is amended to read:

191.16 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
191.17 **PROGRAMS.**

191.18 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health
191.19 maintenance organization, as defined in chapter 62D, must participate as a provider or
191.20 contractor in the medical assistance program and MinnesotaCare as a condition of
191.21 participating as a provider in health insurance plans and programs or contractor for state
191.22 employees established under section 43A.18, the public employees insurance program under
191.23 section 43A.316, for health insurance plans offered to local statutory or home rule charter
191.24 city, county, and school district employees, the workers' compensation system under section
191.25 176.135, and insurance plans provided through the Minnesota Comprehensive Health
191.26 Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to
191.27 local government employees shall not be applicable in geographic areas where provider
191.28 participation is limited by managed care contracts with the Department of Human Services.
191.29 This section does not apply to dental service providers providing dental services outside
191.30 the seven-county metropolitan area.

191.31 (b) For providers other than health maintenance organizations, participation in the medical
191.32 assistance program means that:

192.1 (1) the provider accepts new medical assistance and MinnesotaCare patients;

192.2 (2) for providers other than dental service providers, at least 20 percent of the provider's
192.3 patients are covered by medical assistance and MinnesotaCare as their primary source of
192.4 coverage; or

192.5 (3) for dental service providers providing dental services in the seven-county metropolitan
192.6 area, at least ten percent of the provider's patients are covered by medical assistance and
192.7 MinnesotaCare as their primary source of coverage, or the provider accepts new medical
192.8 assistance and MinnesotaCare patients who are children with special health care needs. For
192.9 purposes of this section, "children with special health care needs" means children up to age
192.10 18 who: (i) require health and related services beyond that required by children generally;
192.11 and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional
192.12 condition, including: bleeding and coagulation disorders; immunodeficiency disorders;
192.13 cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other
192.14 neurological diseases; visual impairment or deafness; Down syndrome and other genetic
192.15 disorders; autism; fetal alcohol syndrome; and other conditions designated by the
192.16 commissioner after consultation with representatives of pediatric dental providers and
192.17 consumers.

192.18 (c) Patients seen on a volunteer basis by the provider at a location other than the provider's
192.19 usual place of practice may be considered in meeting the participation requirement in this
192.20 section. The commissioner shall establish participation requirements for health maintenance
192.21 organizations. The commissioner shall provide lists of participating medical assistance
192.22 providers on a quarterly basis to the commissioner of management and budget, the
192.23 commissioner of labor and industry, and the commissioner of commerce. Each of the
192.24 commissioners shall develop and implement procedures to exclude as participating providers
192.25 in the program or programs under their jurisdiction those providers who do not participate
192.26 in the medical assistance program. The commissioner of management and budget shall
192.27 implement this section through contracts with participating health and dental carriers.

192.28 (d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625,
192.29 subdivision 9a, shall not be considered to be participating in medical assistance or
192.30 MinnesotaCare for the purpose of this section.

192.31 **EFFECTIVE DATE.** This section is effective upon receipt of any necessary federal
192.32 waiver or approval. The commissioner of human services shall notify the revisor of statutes
192.33 if a federal waiver or approval is sought and, if sought, when a federal waiver or approval
192.34 is obtained.

193.1 Sec. 39. Minnesota Statutes 2016, section 256B.072, is amended to read:

193.2 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**
193.3 **SYSTEM.**

193.4 Subdivision 1. Performance measures. (a) The commissioner of human services shall
193.5 establish a performance reporting system for health care providers who provide health care
193.6 services to public program recipients covered under chapters 256B, 256D, and 256L,
193.7 reporting separately for managed care and fee-for-service recipients.

193.8 (b) The measures used for the performance reporting system for medical groups shall
193.9 include measures of care for asthma, diabetes, hypertension, and coronary artery disease
193.10 and measures of preventive care services. The measures used for the performance reporting
193.11 system for inpatient hospitals shall include measures of care for acute myocardial infarction,
193.12 heart failure, and pneumonia, and measures of care and prevention of surgical infections.
193.13 In the case of a medical group, the measures used shall be consistent with ~~measures published~~
193.14 ~~by nonprofit Minnesota or national organizations that produce and disseminate health care~~
193.15 ~~quality measures or evidence-based health care guidelines~~ section 62U.02, subdivision 1,
193.16 paragraph (a), clause (1). In the case of inpatient hospital measures, the commissioner shall
193.17 appoint the Minnesota Hospital Association and Stratis Health to advise on the development
193.18 of the performance measures to be used for hospital reporting. To enable a consistent
193.19 measurement process across the community, the commissioner may use measures of care
193.20 provided for patients in addition to those identified in paragraph (a). The commissioner
193.21 shall ensure collaboration with other health care reporting organizations so that the measures
193.22 described in this section are consistent with those reported by those organizations and used
193.23 by other purchasers in Minnesota.

193.24 (c) The commissioner may require providers to submit information in a required format
193.25 to a health care reporting organization or to cooperate with the information collection
193.26 procedures of that organization. The commissioner may collaborate with a reporting
193.27 organization to collect information reported and to prevent duplication of reporting.

193.28 (d) By October 1, 2007, and annually thereafter, the commissioner shall report through
193.29 a public Web site the results by medical groups and hospitals, where possible, of the measures
193.30 under this section, and shall compare the results by medical groups and hospitals for patients
193.31 enrolled in public programs to patients enrolled in private health plans. To achieve this
193.32 reporting, the commissioner may collaborate with a health care reporting organization that
193.33 operates a Web site suitable for this purpose.

194.1 (e) Performance measures must be stratified as provided under section 62U.02,
 194.2 subdivision 1, paragraph ~~(b)~~ (c), and risk-adjusted as specified in section 62U.02, subdivision
 194.3 3, paragraph (b).

194.4 (f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider
 194.5 and appropriately adjust quality metrics and benchmarks for providers who primarily serve
 194.6 socioeconomically complex patient populations and request to be scored on additional
 194.7 measures in this subdivision. This applies to all Minnesota health care programs, including
 194.8 for patient populations enrolled in health plans, county-based purchasing plans, or managed
 194.9 care organizations and for value-based purchasing arrangements, including, but not limited
 194.10 to, initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and
 194.11 256B.0757.

194.12 (g) Assessment of patient satisfaction with chronic pain management for the purpose of
 194.13 determining compensation or quality incentive payments is prohibited. The commissioner
 194.14 shall require managed care plans, county-based purchasing plans, and integrated health
 194.15 partnerships to comply with this requirement as a condition of contract. This prohibition
 194.16 does not apply to:

194.17 (1) assessing patient satisfaction with chronic pain management for the purpose of quality
 194.18 improvement; and

194.19 (2) pain management as a part of a palliative care treatment plan to treat patients with
 194.20 cancer or patients receiving hospice care.

194.21 **Subd. 2. Adjustment of quality metrics for special populations.** Notwithstanding
 194.22 subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and
 194.23 appropriately adjust quality metrics and benchmarks for providers who primarily serve
 194.24 socio-economically complex patient populations and request to be scored on additional
 194.25 measures in this subdivision. This requirement applies to all medical assistance and
 194.26 MinnesotaCare programs and enrollees, including persons enrolled in managed care and
 194.27 county-based purchasing plans or other managed care organizations, persons receiving care
 194.28 under fee-for-service, and persons receiving care under value-based purchasing arrangements,
 194.29 including but not limited to initiatives operating under sections 256B.0751, 256B.0753,
 194.30 256B.0755, 256B.0756, and 256B.0757.

194.31 Sec. 40. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

194.32 Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~
 194.33 continue a demonstration project established under this section to test alternative and

195.1 innovative integrated health care delivery systems partnerships, including accountable care
195.2 organizations that provide services to a specified patient population for an agreed-upon total
195.3 cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a
195.4 request for proposals for participation in the demonstration project in consultation with
195.5 hospitals, primary care providers, health plans, and other key stakeholders.

195.6 (b) In developing the request for proposals, the commissioner shall:

195.7 (1) establish uniform statewide methods of forecasting utilization and cost of care for
195.8 the appropriate Minnesota public program populations, to be used by the commissioner for
195.9 the ~~health care delivery system~~ integrated health partnership projects;

195.10 (2) identify key indicators of quality, access, patient satisfaction, and other performance
195.11 indicators that will be measured, in addition to indicators for measuring cost savings;

195.12 (3) allow maximum flexibility to encourage innovation and variation so that a variety
195.13 of provider collaborations are able to become ~~health care delivery systems~~ integrated health
195.14 partnerships, and may be customized for the special needs and barriers of patient populations
195.15 experiencing health disparities due to social, economic, racial, or ethnic factors;

195.16 (4) encourage and authorize different levels and types of financial risk;

195.17 (5) encourage and authorize projects representing a wide variety of geographic locations,
195.18 patient populations, provider relationships, and care coordination models;

195.19 (6) encourage projects that involve close partnerships between the ~~health care delivery~~
195.20 ~~system~~ integrated health partnership and counties and nonprofit agencies that provide services
195.21 to patients enrolled with the ~~health care delivery system~~ integrated health partnership,
195.22 including social services, public health, mental health, community-based services, and
195.23 continuing care;

195.24 (7) encourage projects established by community hospitals, clinics, and other providers
195.25 in rural communities;

195.26 (8) identify required covered services for a total cost of care model or services considered
195.27 in whole or partially in an analysis of utilization for a risk/gain sharing model;

195.28 (9) establish a mechanism to monitor enrollment;

195.29 (10) establish quality standards for the ~~delivery system~~ integrated health partnership
195.30 demonstrations that are appropriate for the particular patient population to be served; and

195.31 (11) encourage participation of privately insured population so as to create sufficient
195.32 alignment in demonstration systems.

196.1 (c) To be eligible to participate in ~~the demonstration project~~ an integrated health
196.2 partnership, a health care delivery system must:

196.3 (1) provide required covered services and care coordination to recipients enrolled in the
196.4 ~~health care delivery system~~ integrated health partnership;

196.5 (2) establish a process to monitor enrollment and ensure the quality of care provided;

196.6 (3) in cooperation with counties and community social service agencies, coordinate the
196.7 delivery of health care services with existing social services programs;

196.8 (4) provide a system for advocacy and consumer protection; and

196.9 (5) adopt innovative and cost-effective methods of care delivery and coordination, which
196.10 may include the use of allied health professionals, telemedicine, patient educators, care
196.11 coordinators, and community health workers.

196.12 (d) ~~A health care delivery system~~ An integrated health partnership demonstration may
196.13 be formed by the following groups of providers of services and suppliers if they have
196.14 established a mechanism for shared governance:

196.15 (1) professionals in group practice arrangements;

196.16 (2) networks of individual practices of professionals;

196.17 (3) partnerships or joint venture arrangements between hospitals and health care
196.18 professionals;

196.19 (4) hospitals employing professionals; and

196.20 (5) other groups of providers of services and suppliers as the commissioner determines
196.21 appropriate.

196.22 A managed care plan or county-based purchasing plan may participate in this
196.23 demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

196.24 ~~A health care delivery system~~ An integrated health partnership may contract with a
196.25 managed care plan or a county-based purchasing plan to provide administrative services,
196.26 including the administration of a payment system using the payment methods established
196.27 by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

196.28 (e) The commissioner may require ~~a health care delivery system~~ an integrated health
196.29 partnership to enter into additional third-party contractual relationships for the assessment
196.30 of risk and purchase of stop loss insurance or another form of insurance risk management
196.31 related to the delivery of care described in paragraph (c).

197.1 **EFFECTIVE DATE.** This section is effective January 1, 2018.

197.2 Sec. 41. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

197.3 Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships
197.4 must accept responsibility for the quality of care based on standards established under
197.5 subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services
197.6 provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability
197.7 standards must be appropriate to the particular population served.

197.8 (b) ~~A health care delivery system~~ An integrated health partnership may contract and
197.9 coordinate with providers and clinics for the delivery of services and shall contract with
197.10 community health clinics, federally qualified health centers, community mental health
197.11 centers or programs, county agencies, and rural clinics to the extent practicable.

197.12 (c) ~~A health care delivery system~~ An integrated health partnership must indicate how it
197.13 will coordinate with other services affecting its patients' health, quality of care, and cost of
197.14 care that are provided by other providers, county agencies, and other organizations in the
197.15 local service area. The ~~health care delivery system~~ integrated health partnership must indicate
197.16 how it will engage other providers, counties, and organizations, including county-based
197.17 purchasing plans, that provide services to patients of the ~~health care delivery system~~
197.18 integrated health partnership on issues related to local population health, including applicable
197.19 local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated
197.20 health partnership must describe how local providers, counties, organizations, including
197.21 county-based purchasing plans, and other relevant purchasers were consulted in developing
197.22 the application to participate in the demonstration project.

197.23 Sec. 42. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

197.24 Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery~~
197.25 ~~systems~~ integrated health partnerships, the commissioner shall establish a total cost of care
197.26 benchmark or a risk/gain sharing payment model to be paid for services provided to the
197.27 recipients enrolled in a ~~health care delivery system~~ an integrated health partnership.

197.28 (b) The payment system may include incentive payments to ~~health care delivery systems~~
197.29 integrated health partnerships that meet or exceed annual quality and performance targets
197.30 realized through the coordination of care.

197.31 (c) An amount equal to the savings realized to the general fund as a result of the
197.32 demonstration project shall be transferred each fiscal year to the health care access fund.

198.1 (d) The payment system shall include a population-based payment that supports care
 198.2 coordination services for all enrollees served by the integrated health partnerships, and is
 198.3 risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with
 198.4 chronic conditions, limited English skills, cultural differences, are homeless, or experience
 198.5 health disparities or other barriers to health care. The population-based payment shall be a
 198.6 per member, per month payment paid at least on a quarterly basis. Integrated health
 198.7 partnerships receiving this payment must continue to meet cost and quality metrics under
 198.8 the program to maintain eligibility for the population-based payment. An integrated health
 198.9 partnership is eligible to receive a payment under this paragraph even if the partnership is
 198.10 not participating in a risk-based or gain-sharing payment model and regardless of the size
 198.11 of the patient population served by the integrated health partnership. Any integrated health
 198.12 partnership participant certified as a health care home under section 256B.0751 that agrees
 198.13 to a payment method that includes population-based payments for care coordination is not
 198.14 eligible to receive health care home payment or care coordination fee authorized under
 198.15 section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section
 198.16 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled
 198.17 or attributed to the integrated health partnership under this demonstration.

198.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

198.19 Sec. 43. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision
 198.20 to read:

198.21 Subd. 9. **Patient incentives.** The commissioner may authorize an integrated health
 198.22 partnership to provide incentives for patients to:

198.23 (1) see a primary care provider for an initial health assessment;

198.24 (2) maintain a continuous relationship with the primary care provider; and

198.25 (3) participate in ongoing health improvement and coordination of care activities.

198.26 Sec. 44. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision
 198.27 to read:

198.28 Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal
 198.29 approval, contact made for targeted case management by interactive video shall be eligible
 198.30 for payment under subdivision 6 if:

198.31 (1) the person receiving targeted case management services is residing in:

198.32 (i) a hospital;

- 199.1 (ii) a nursing facility; or
- 199.2 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
- 199.3 establishment or lodging establishment that provides supportive services or health supervision
- 199.4 services according to section 157.17 that is staffed 24 hours a day, seven days a week;
- 199.5 (2) interactive video is in the best interests of the person and is deemed appropriate by
- 199.6 the person receiving targeted case management or the person's legal guardian, the case
- 199.7 management provider, and the provider operating the setting where the person is residing;
- 199.8 (3) the use of interactive video is approved as part of the person's written personal service
- 199.9 or case plan; and
- 199.10 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
- 199.11 required face-to-face contact.
- 199.12 (b) The person receiving targeted case management or the person's legal guardian has
- 199.13 the right to choose and consent to the use of interactive video under this subdivision and
- 199.14 has the right to refuse the use of interactive video at any time.
- 199.15 (c) The commissioner shall establish criteria that a targeted case management provider
- 199.16 must attest to in order to demonstrate the safety or efficacy of delivering the service via
- 199.17 interactive video. The attestation may include that the case management provider has:
- 199.18 (1) written policies and procedures specific to interactive video services that are regularly
- 199.19 reviewed and updated;
- 199.20 (2) policies and procedures that adequately address client safety before, during, and after
- 199.21 the interactive video services are rendered;
- 199.22 (3) established protocols addressing how and when to discontinue interactive video
- 199.23 services; and
- 199.24 (4) established a quality assurance process related to interactive video services.
- 199.25 (d) As a condition of payment, the targeted case management provider must document
- 199.26 the following for each occurrence of targeted case management provided by interactive
- 199.27 video:
- 199.28 (1) the time the service began and the time the service ended, including an a.m. and p.m.
- 199.29 designation;
- 199.30 (2) the basis for determining that interactive video is an appropriate and effective means
- 199.31 for delivering the service to the person receiving case management services;

200.1 (3) the mode of transmission of the interactive video services and records evidencing
200.2 that a particular mode of transmission was utilized;

200.3 (4) the location of the originating site and the distant site; and

200.4 (5) compliance with the criteria attested to by the targeted case management provider
200.5 as provided in paragraph (c).

200.6 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
200.7 of human services shall notify the revisor of statutes when federal approval is obtained.

200.8 Sec. 45. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

200.9 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
200.10 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
200.11 payment limit for nonstate government hospitals. The commissioner shall then determine
200.12 the amount of a supplemental payment to Hennepin County Medical Center and Regions
200.13 Hospital for these services that would increase medical assistance spending in this category
200.14 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
200.15 In making this determination, the commissioner shall allot the available increases between
200.16 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
200.17 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
200.18 shall adjust this allotment as necessary based on federal approvals, the amount of
200.19 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
200.20 in order to maximize the additional total payments. The commissioner shall inform Hennepin
200.21 County and Ramsey County of the periodic intergovernmental transfers necessary to match
200.22 federal Medicaid payments available under this subdivision in order to make supplementary
200.23 medical assistance payments to Hennepin County Medical Center and Regions Hospital
200.24 equal to an amount that when combined with existing medical assistance payments to
200.25 nonstate governmental hospitals would increase total payments to hospitals in this category
200.26 for outpatient services to the aggregate upper payment limit for all hospitals in this category
200.27 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
200.28 supplementary payments to Hennepin County Medical Center and Regions Hospital.

200.29 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
200.30 determine an upper payment limit for physicians and other billing professionals affiliated
200.31 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit
200.32 shall be based on the average commercial rate or be determined using another method
200.33 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
200.34 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers

201.1 necessary to match the federal Medicaid payments available under this subdivision in order
201.2 to make supplementary payments to physicians and other billing professionals affiliated
201.3 with Hennepin County Medical Center and to make supplementary payments to physicians
201.4 and other billing professionals affiliated with Regions Hospital through HealthPartners
201.5 Medical Group equal to the difference between the established medical assistance payment
201.6 for physician and other billing professional services and the upper payment limit. Upon
201.7 receipt of these periodic transfers, the commissioner shall make supplementary payments
201.8 to physicians and other billing professionals affiliated with Hennepin County Medical Center
201.9 and shall make supplementary payments to physicians and other billing professionals
201.10 affiliated with Regions Hospital through HealthPartners Medical Group.

201.11 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly
201.12 voluntary intergovernmental transfers to the commissioner in amounts not to exceed
201.13 \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.
201.14 The commissioner shall increase the medical assistance capitation payments to any licensed
201.15 health plan under contract with the medical assistance program that agrees to make enhanced
201.16 payments to Hennepin County Medical Center or Regions Hospital. The increase shall be
201.17 in an amount equal to the annual value of the monthly transfers plus federal financial
201.18 participation, with each health plan receiving its pro rata share of the increase based on the
201.19 pro rata share of medical assistance admissions to Hennepin County Medical Center and
201.20 Regions Hospital by those plans. For the purposes of this paragraph, "the base amount"
201.21 means the total annual value of increased medical assistance capitation payments under this
201.22 paragraph in calendar year 2017. For managed care contracts beginning on or after January
201.23 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance
201.24 capitation payments under this paragraph by an amount equal to ten percent of the base
201.25 amount, and by an additional ten percent of the base amount for each subsequent contract
201.26 year until December 31, 2025. Upon the request of the commissioner, health plans shall
201.27 submit individual-level cost data for verification purposes. The commissioner may ratably
201.28 reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial
201.29 soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed
201.30 health plan that receives increased medical assistance capitation payments under the
201.31 intergovernmental transfer described in this paragraph shall increase its medical assistance
201.32 payments to Hennepin County Medical Center and Regions Hospital by the same amount
201.33 as the increased payments received in the capitation payment described in this paragraph.
201.34 This paragraph expires January 1, 2026.

202.1 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
202.2 determine an upper payment limit for ambulance services affiliated with Hennepin County
202.3 Medical Center and the city of St. Paul, and ambulance services owned and operated by
202.4 another governmental entity that chooses to participate by requesting the commissioner to
202.5 determine an upper payment limit. The upper payment limit shall be based on the average
202.6 commercial rate or be determined using another method acceptable to the Centers for
202.7 Medicare and Medicaid Services. The commissioner shall inform Hennepin County ~~and,~~
202.8 the city of St. Paul, and other participating governmental entities of the periodic
202.9 intergovernmental transfers necessary to match the federal Medicaid payments available
202.10 under this subdivision in order to make supplementary payments to Hennepin County
202.11 Medical Center ~~and,~~ the city of St. Paul, and other participating governmental entities equal
202.12 to the difference between the established medical assistance payment for ambulance services
202.13 and the upper payment limit. Upon receipt of these periodic transfers, the commissioner
202.14 shall make supplementary payments to Hennepin County Medical Center ~~and,~~ the city of
202.15 St. Paul, and other participating governmental entities. A tribal government that owns and
202.16 operates an ambulance service is not eligible to participate under this subdivision.

202.17 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall
202.18 determine an upper payment limit for physicians, dentists, and other billing professionals
202.19 affiliated with the University of Minnesota and University of Minnesota Physicians. The
202.20 upper payment limit shall be based on the average commercial rate or be determined using
202.21 another method acceptable to the Centers for Medicare and Medicaid Services. The
202.22 commissioner shall inform the University of Minnesota Medical School and University of
202.23 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to
202.24 match the federal Medicaid payments available under this subdivision in order to make
202.25 supplementary payments to physicians, dentists, and other billing professionals affiliated
202.26 with the University of Minnesota and the University of Minnesota Physicians equal to the
202.27 difference between the established medical assistance payment for physician, dentist, and
202.28 other billing professional services and the upper payment limit. Upon receipt of these periodic
202.29 transfers, the commissioner shall make supplementary payments to physicians, dentists,
202.30 and other billing professionals affiliated with the University of Minnesota and the University
202.31 of Minnesota Physicians.

202.32 (f) The commissioner shall inform the transferring governmental entities on an ongoing
202.33 basis of the need for any changes needed in the intergovernmental transfers in order to
202.34 continue the payments under paragraphs (a) to ~~(d)~~ (e), at their maximum level, including
202.35 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

203.1 ~~(f)~~ (g) The payments in paragraphs (a) to ~~(d)~~ (e) shall be implemented independently of
 203.2 each other, subject to federal approval and to the receipt of transfers under subdivision 3.

203.3 (h) All of the data and funding transactions related to the payments in paragraphs (a) to
 203.4 (e) shall be between the commissioner and the governmental entities.

203.5 (i) For purposes of this subdivision, billing professionals are limited to physicians, nurse
 203.6 practitioners, nurse midwives, clinical nurse specialists, physician assistants,
 203.7 anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and
 203.8 dental therapists.

203.9 **EFFECTIVE DATE.** Paragraph (d) is effective July 1, 2017, or upon federal approval,
 203.10 whichever is later. The commissioner of human services shall notify the revisor of statutes
 203.11 when federal approval is received.

203.12 Sec. 46. Minnesota Statutes 2016, section 256B.196, subdivision 3, is amended to read:

203.13 Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner
 203.14 under subdivision 2, Hennepin County and Ramsey County shall make periodic
 203.15 intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs
 203.16 (a) and (b). All of the intergovernmental transfers made by Hennepin County shall be used
 203.17 to match federal payments to Hennepin County Medical Center under subdivision 2,
 203.18 paragraph (a), and to physicians and other billing professionals affiliated with Hennepin
 203.19 County Medical Center under subdivision 2, paragraph (b). All of the intergovernmental
 203.20 transfers made by Ramsey County shall be used to match federal payments to Regions
 203.21 Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals
 203.22 affiliated with Regions Hospital through HealthPartners Medical Group under subdivision
 203.23 2, paragraph (b). All of the intergovernmental transfer payments made by the University of
 203.24 Minnesota Medical School and the University of Minnesota School of Dentistry shall be
 203.25 used to match federal payments to the University of Minnesota and the University of
 203.26 Minnesota Physicians under subdivision 2, paragraph (e).

203.27 Sec. 47. Minnesota Statutes 2016, section 256B.196, subdivision 4, is amended to read:

203.28 Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the
 203.29 intergovernmental transfers under subdivision 3 and the payments under subdivision 2,
 203.30 based on the commissioner's determination of Medicare upper payment limits,
 203.31 hospital-specific charge limits, hospital-specific limitations on disproportionate share
 203.32 payments, medical inflation, actuarial certification, average commercial rates for physician
 203.33 and other professional services as defined in this section, and cost-effectiveness for purposes

204.1 of federal waivers. Any adjustments must be made on a proportional basis. The commissioner
 204.2 may make adjustments under this subdivision only after consultation with the affected
 204.3 counties, university schools, and hospitals. All payments under subdivision 2 and all
 204.4 intergovernmental transfers under subdivision 3 are limited to amounts available after all
 204.5 other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

204.6 (b) The ratio of medical assistance payments specified in subdivision 2 to the voluntary
 204.7 intergovernmental transfers specified in subdivision 3 shall not be reduced except as provided
 204.8 under paragraph (a).

204.9 Sec. 48. Minnesota Statutes 2016, section 256B.69, subdivision 9e, is amended to read:

204.10 Subd. 9e. **Financial audits.** ~~(a) The legislative auditor shall conduct or contract with~~
 204.11 ~~vendors to conduct independent third-party financial audits of the information required to~~
 204.12 ~~be provided by~~ audit managed care plans and county-based purchasing plans under
 204.13 ~~subdivision 9e, paragraph (b). The audits by the vendors shall be conducted as vendor~~
 204.14 ~~resources permit and in accordance with generally accepted government auditing standards~~
 204.15 ~~issued by the United States Government Accountability Office. The contract with the vendors~~
 204.16 ~~shall be designed and administered so as to render the independent third-party audits eligible~~
 204.17 ~~for a federal subsidy, if available. The contract shall require the audits to include a~~
 204.18 ~~determination of compliance with the federal Medicaid rate certification process to determine~~
 204.19 if a managed care plan or county-based purchasing plan used public money in compliance
 204.20 with federal and state laws, rules, and in accordance with provisions in the plan's contract
 204.21 with the commissioner. The legislative auditor shall conduct the audits in accordance with
 204.22 section 3.972, subdivision 2b.

204.23 ~~(b) For purposes of this subdivision, "independent third-party" means a vendor that is~~
 204.24 ~~independent in accordance with government auditing standards issued by the United States~~
 204.25 ~~Government Accountability Office.~~

204.26 Sec. 49. Minnesota Statutes 2016, section 256B.75, is amended to read:

204.27 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

204.28 (a) For outpatient hospital facility fee payments for services rendered on or after October
 204.29 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
 204.30 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
 204.31 which there is a federal maximum allowable payment. Effective for services rendered on
 204.32 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
 204.33 emergency room facility fees shall be increased by eight percent over the rates in effect on

205.1 December 31, 1999, except for those services for which there is a federal maximum allowable
205.2 payment. Services for which there is a federal maximum allowable payment shall be paid
205.3 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
205.4 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
205.5 upper limit. If it is determined that a provision of this section conflicts with existing or
205.6 future requirements of the United States government with respect to federal financial
205.7 participation in medical assistance, the federal requirements prevail. The commissioner
205.8 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
205.9 participation resulting from rates that are in excess of the Medicare upper limitations.

205.10 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
205.11 surgery hospital facility fee services for critical access hospitals designated under section
205.12 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
205.13 cost-finding methods and allowable costs of the Medicare program. Effective for services
205.14 provided on or after July 1, 2015, rates established for critical access hospitals under this
205.15 paragraph for the applicable payment year shall be the final payment and shall not be settled
205.16 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
205.17 year ending in 2016, the rate for outpatient hospital services shall be computed using
205.18 information from each hospital's Medicare cost report as filed with Medicare for the year
205.19 that is two years before the year that the rate is being computed. Rates shall be computed
205.20 using information from Worksheet C series until the department finalizes the medical
205.21 assistance cost reporting process for critical access hospitals. After the cost reporting process
205.22 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
205.23 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
205.24 related to rural health clinics and federally qualified health clinics, divided by ancillary
205.25 charges plus outpatient charges, excluding charges related to rural health clinics and federally
205.26 qualified health clinics.

205.27 (c) Effective for services provided on or after July 1, 2003, rates that are based on the
205.28 Medicare outpatient prospective payment system shall be replaced by a budget neutral
205.29 prospective payment system that is derived using medical assistance data. The commissioner
205.30 shall provide a proposal to the 2003 legislature to define and implement this provision.

205.31 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
205.32 before third-party liability and spenddown, made to hospitals for outpatient hospital facility
205.33 services is reduced by .5 percent from the current statutory rate.

205.34 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
205.35 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility

206.1 services before third-party liability and spenddown, is reduced five percent from the current
206.2 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from
206.3 this paragraph.

206.4 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
206.5 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
206.6 hospital facility services before third-party liability and spenddown, is reduced three percent
206.7 from the current statutory rates. Mental health services and facilities defined under section
206.8 256.969, subdivision 16, are excluded from this paragraph.

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

206.10 Sec. 50. Minnesota Statutes 2016, section 256B.76, subdivision 1, as amended by Laws
206.11 2017, chapter 40, article 1, section 79, is amended to read:

206.12 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after
206.13 October 1, 1992, the commissioner shall make payments for physician services as follows:

206.14 (1) payment for level one Centers for Medicare and Medicaid Services' common
206.15 procedural coding system codes titled "office and other outpatient services," "preventive
206.16 medicine new and established patient," "delivery, antepartum, and postpartum care," "critical
206.17 care," cesarean delivery and pharmacologic management provided to psychiatric patients,
206.18 and level three codes for enhanced services for prenatal high risk, shall be paid at the lower
206.19 of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

206.20 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
206.21 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

206.22 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
206.23 percentile of 1989, less the percent in aggregate necessary to equal the above increases
206.24 except that payment rates for home health agency services shall be the rates in effect on
206.25 September 30, 1992.

206.26 (b) Effective for services rendered on or after January 1, 2000, payment rates for physician
206.27 and professional services shall be increased by three percent over the rates in effect on
206.28 December 31, 1999, except for home health agency and family planning agency services.
206.29 The increases in this paragraph shall be implemented January 1, 2000, for managed care.

206.30 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
206.31 and professional services shall be reduced by five percent, except that for the period July
206.32 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical
206.33 assistance and general assistance medical care programs, over the rates in effect on June

207.1 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
207.2 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
207.3 advanced practice nurses, or physician assistants in a family planning agency or in one of
207.4 the following primary care practices: general practice, general internal medicine, general
207.5 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in
207.6 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
207.7 Indian health services. Effective October 1, 2009, payments made to managed care plans
207.8 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
207.9 reflect the payment reduction described in this paragraph.

207.10 (d) Effective for services rendered on or after July 1, 2010, payment rates for physician
207.11 and professional services shall be reduced an additional seven percent over the five percent
207.12 reduction in rates described in paragraph (c). This additional reduction does not apply to
207.13 physical therapy services, occupational therapy services, and speech pathology and related
207.14 services provided on or after July 1, 2010. This additional reduction does not apply to
207.15 physician services billed by a psychiatrist or an advanced practice nurse with a specialty in
207.16 mental health. Effective October 1, 2010, payments made to managed care plans and
207.17 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
207.18 the payment reduction described in this paragraph.

207.19 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,
207.20 payment rates for physician and professional services shall be reduced three percent from
207.21 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy
207.22 services, occupational therapy services, and speech pathology and related services.

207.23 (f) Effective for services rendered on or after September 1, 2014, payment rates for
207.24 physician and professional services, including physical therapy, occupational therapy, speech
207.25 pathology, and mental health services shall be increased by five percent from the rates in
207.26 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
207.27 include in the base rate for August 31, 2014, the rate increase provided under section
207.28 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
207.29 rural health centers, and Indian health services. Payments made to managed care plans and
207.30 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

207.31 (g) Effective for services rendered on or after July 1, 2015, payment rates for physical
207.32 therapy, occupational therapy, and speech pathology and related services provided by a
207.33 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
207.34 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments

208.1 made to managed care plans and county-based purchasing plans shall not be adjusted to
208.2 reflect payments under this paragraph.

208.3 (h) Any ratables effective before July 1, 2015, do not apply to autism early intensive
208.4 intervention benefits described in section 256B.0949.

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

208.6 Sec. 51. Minnesota Statutes 2016, section 256B.76, subdivision 2, is amended to read:

208.7 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
208.8 1, 1992, the commissioner shall make payments for dental services as follows:

208.9 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent
208.10 above the rate in effect on June 30, 1992; and

208.11 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile
208.12 of 1989, less the percent in aggregate necessary to equal the above increases.

208.13 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
208.14 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

208.15 (c) Effective for services rendered on or after January 1, 2000, payment rates for dental
208.16 services shall be increased by three percent over the rates in effect on December 31, 1999.

208.17 (d) Effective for services provided on or after January 1, 2002, payment for diagnostic
208.18 examinations and dental x-rays provided to children under age 21 shall be the lower of (1)
208.19 the submitted charge, or (2) 85 percent of median 1999 charges.

208.20 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000,
208.21 for managed care.

208.22 (f) Effective for dental services rendered on or after October 1, 2010, by a state-operated
208.23 dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare
208.24 principles of reimbursement. This payment shall be effective for services rendered on or
208.25 after January 1, 2011, to recipients enrolled in managed care plans or county-based
208.26 purchasing plans.

208.27 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in
208.28 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a
208.29 supplemental state payment equal to the difference between the total payments in paragraph
208.30 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the
208.31 operation of the dental clinics.

209.1 (h) If the cost-based payment system for state-operated dental clinics described in
209.2 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
209.3 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
209.4 receive the critical access dental reimbursement rate as described under subdivision 4,
209.5 paragraph (a).

209.6 (i) Effective for services rendered on or after September 1, 2011, through June 30, 2013,
209.7 payment rates for dental services shall be reduced by three percent. This reduction does not
209.8 apply to state-operated dental clinics in paragraph (f).

209.9 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental
209.10 services shall be increased by five percent from the rates in effect on December 31, 2013.
209.11 This increase does not apply to state-operated dental clinics in paragraph (f), federally
209.12 qualified health centers, rural health centers, and Indian health services. Effective January
209.13 1, 2014, payments made to managed care plans and county-based purchasing plans under
209.14 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in
209.15 this paragraph.

209.16 (k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,
209.17 the commissioner shall increase payment rates for services furnished by dental providers
209.18 located outside of the seven-county metropolitan area by the maximum percentage possible
209.19 above the rates in effect on June 30, 2015, while remaining within the limits of funding
209.20 appropriated for this purpose. This increase does not apply to state-operated dental clinics
209.21 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
209.22 services. Effective January 1, 2016, through December 31, 2016, payments to managed care
209.23 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
209.24 the payment increase described in this paragraph. The commissioner shall require managed
209.25 care and county-based purchasing plans to pass on the full amount of the increase, in the
209.26 form of higher payment rates to dental providers located outside of the seven-county
209.27 metropolitan area.

209.28 (l) Effective for services provided on or after January 1, 2017, the commissioner shall
209.29 increase payment rates by 9.65 percent for dental services provided outside of the
209.30 seven-county metropolitan area. This increase does not apply to state-operated dental clinics
209.31 in paragraph (f), federally qualified health centers, rural health centers, or Indian health
209.32 services. Effective January 1, 2017, payments to managed care plans and county-based
209.33 purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase
209.34 described in this paragraph.

210.1 (m) Effective for services provided on or after July 1, 2017, the commissioner shall
210.2 increase payment rates by 23.8 percent for dental services provided to enrollees under the
210.3 age of 21. This increase does not apply to state-operated dental clinics in paragraph (f),
210.4 federally qualified health centers, rural health centers, or Indian health centers. Payments
210.5 made to managed care plans and county-based purchasing plans shall not be adjusted to
210.6 reflect the payment increase under this paragraph.

210.7 Sec. 52. Minnesota Statutes 2016, section 256B.761, is amended to read:

210.8 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

210.9 (a) Effective for services rendered on or after July 1, 2001, payment for medication
210.10 management provided to psychiatric patients, outpatient mental health services, day treatment
210.11 services, home-based mental health services, and family community support services shall
210.12 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
210.13 1999 charges.

210.14 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
210.15 services provided by an entity that operates: (1) a Medicare-certified comprehensive
210.16 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,
210.17 with at least 33 percent of the clients receiving rehabilitation services in the most recent
210.18 calendar year who are medical assistance recipients, will be increased by 38 percent, when
210.19 those services are provided within the comprehensive outpatient rehabilitation facility and
210.20 provided to residents of nursing facilities owned by the entity.

210.21 (c) The commissioner shall establish three levels of payment for mental health diagnostic
210.22 assessment, based on three levels of complexity. The aggregate payment under the tiered
210.23 rates must not exceed the projected aggregate payments for mental health diagnostic
210.24 assessment under the previous single rate. The new rate structure is effective January 1,
210.25 2011, or upon federal approval, whichever is later.

210.26 (d) In addition to rate increases otherwise provided, the commissioner may restructure
210.27 coverage policy and rates to improve access to adult rehabilitative mental health services
210.28 under section 256B.0623 and related mental health support services under section 256B.021,
210.29 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected
210.30 state share of increased costs due to this paragraph is transferred from adult mental health
210.31 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent
210.32 base adjustment for subsequent fiscal years. Payments made to managed care plans and
210.33 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
210.34 the rate changes described in this paragraph.

211.1 (e) Any ratables effective before July 1, 2015, do not apply to autism early intensive
 211.2 intervention benefits described in section 256B.0949.

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

211.4 Sec. 53. **[256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC**
 211.5 **HEALTH NURSE HOME VISITS.**

211.6 Effective for services provided on or after January 1, 2018, prenatal and postpartum
 211.7 follow-up home visits provided by public health nurses or registered nurses supervised by
 211.8 a public health nurse using evidence-based models shall be paid \$140 per visit.
 211.9 Evidence-based postpartum follow-up home visits must be administered by home visiting
 211.10 programs that meet the United States Department of Health and Human Services criteria
 211.11 for evidence-based models and are identified by the commissioner of health as eligible to
 211.12 be implemented under the Maternal, Infant, and Early Childhood Home Visiting program.
 211.13 Home visits must target mothers and their children beginning with prenatal visits through
 211.14 age three for the child.

211.15 Sec. 54. Minnesota Statutes 2016, section 256B.766, is amended to read:

211.16 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

211.17 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
 211.18 services, shall be reduced by three percent, except that for the period July 1, 2009, through
 211.19 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
 211.20 and general assistance medical care programs, prior to third-party liability and spenddown
 211.21 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
 211.22 occupational therapy services, and speech-language pathology and related services as basic
 211.23 care services. The reduction in this paragraph shall apply to physical therapy services,
 211.24 occupational therapy services, and speech-language pathology and related services provided
 211.25 on or after July 1, 2010.

211.26 (b) Payments made to managed care plans and county-based purchasing plans shall be
 211.27 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
 211.28 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
 211.29 to reflect the reduction effective July 1, 2010.

211.30 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
 211.31 total payments for outpatient hospital facility fees shall be reduced by five percent from the
 211.32 rates in effect on August 31, 2011.

212.1 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
212.2 total payments for ambulatory surgery centers facility fees, medical supplies and durable
212.3 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
212.4 renal dialysis services, laboratory services, public health nursing services, physical therapy
212.5 services, occupational therapy services, speech therapy services, eyeglasses not subject to
212.6 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
212.7 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
212.8 2011.

212.9 (e) Effective for services provided on or after September 1, 2014, payments for
212.10 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
212.11 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
212.12 and hearing aids not subject to a volume purchase contract shall be increased by three percent
212.13 and payments for outpatient hospital facility fees shall be increased by three percent.
212.14 Payments made to managed care plans and county-based purchasing plans shall not be
212.15 adjusted to reflect payments under this paragraph.

212.16 (f) Payments for medical supplies and durable medical equipment not subject to a volume
212.17 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
212.18 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
212.19 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
212.20 provided on or after July 1, 2015, shall be increased by three percent from the rates as
212.21 determined under paragraphs (i) and (j).

212.22 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
212.23 hospital facility fees, medical supplies and durable medical equipment not subject to a
212.24 volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital
212.25 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
212.26 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made
212.27 to managed care plans and county-based purchasing plans shall not be adjusted to reflect
212.28 payments under this paragraph.

212.29 (h) This section does not apply to physician and professional services, inpatient hospital
212.30 services, family planning services, mental health services, dental services, prescription
212.31 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
212.32 health services, and Medicare cost-sharing.

212.33 (i) Effective for services provided on or after July 1, 2015, the following categories of
212.34 medical supplies and durable medical equipment shall be individually priced items: enteral

213.1 nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,
 213.2 electric patient lifts, and durable medical equipment repair and service. This paragraph does
 213.3 not apply to medical supplies and durable medical equipment subject to a volume purchase
 213.4 contract, products subject to the preferred diabetic testing supply program, and items provided
 213.5 to dually eligible recipients when Medicare is the primary payer for the item. The
 213.6 commissioner shall not apply any medical assistance rate reductions to durable medical
 213.7 equipment as a result of Medicare competitive bidding.

213.8 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
 213.9 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
 213.10 as follows:

213.11 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
 213.12 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
 213.13 increased by 9.5 percent; and

213.14 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
 213.15 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
 213.16 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
 213.17 being applied after calculation of any increased payment rate under clause (1).

213.18 This paragraph does not apply to medical supplies and durable medical equipment subject
 213.19 to a volume purchase contract, products subject to the preferred diabetic testing supply
 213.20 program, items provided to dually eligible recipients when Medicare is the primary payer
 213.21 for the item, and individually priced items identified in paragraph (i). Payments made to
 213.22 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
 213.23 rate increases in this paragraph.

213.24 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,
 213.25 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
 213.26 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
 213.27 lower of the submitted charge or 47 percent above the Medicare fee schedule rate, of which
 213.28 payments above the federal upper payment limit shall be state funded.

213.29 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2016.

213.30 Sec. 55. Minnesota Statutes 2016, section 256L.03, subdivision 1, is amended to read:

213.31 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
 213.32 services reimbursed under chapter 256B, with the exception of special education services,
 213.33 home care nursing services, adult dental care services other than services covered under

214.1 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation
 214.2 services, personal care assistance and case management services, and nursing home or
 214.3 intermediate care facilities services.

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

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

214.9 (d) For the purposes of covered health services under this section, "child" means an
 214.10 individual younger than 19 years of age.

214.11 Sec. 56. Minnesota Statutes 2016, section 256L.03, subdivision 1a, is amended to read:

214.12 Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible
 214.13 for coverage of all services that are eligible for reimbursement under the medical assistance
 214.14 program according to chapter 256B, except special education services and that abortion
 214.15 services under MinnesotaCare shall be limited as provided under subdivision 1. Children
 214.16 are exempt from the provisions of subdivision 5, regarding co-payments. Children who are
 214.17 lawfully residing in the United States but who are not "qualified noncitizens" under title IV
 214.18 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public
 214.19 Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all
 214.20 services provided under the medical assistance program according to chapter 256B.

214.21 Sec. 57. Minnesota Statutes 2016, section 256L.03, subdivision 5, is amended to read:

214.22 Subd. 5. **Cost-sharing.** ~~(a) Except as otherwise provided in this subdivision, the~~
 214.23 ~~MinnesotaCare benefit plan shall include the following cost-sharing requirements for all~~
 214.24 ~~enrollees:~~

214.25 ~~(1) \$3 per prescription for adult enrollees;~~

214.26 ~~(2) \$25 for eyeglasses for adult enrollees;~~

214.27 ~~(3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an~~
 214.28 ~~episode of service which is required because of a recipient's symptoms, diagnosis, or~~
 214.29 ~~established illness, and which is delivered in an ambulatory setting by a physician or~~
 214.30 ~~physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse,~~
 214.31 ~~audiologist, optician, or optometrist;~~

215.1 ~~(4) \$6 for nonemergency visits to a hospital-based emergency room for services provided~~
 215.2 ~~through December 31, 2010, and \$3.50 effective January 1, 2011; and~~

215.3 ~~(5) a family deductible equal to \$2.75 per month per family and adjusted annually by~~
 215.4 ~~the percentage increase in the medical care component of the CPI-U for the period of~~
 215.5 ~~September to September of the preceding calendar year, rounded to the next higher five~~
 215.6 ~~cent increment.~~

215.7 ~~(b) Paragraph (a) does~~ (a) Co-payments, coinsurance, and deductibles do not apply to
 215.8 children under the age of 21 and to American Indians as defined in Code of Federal
 215.9 Regulations, title 42, section 447.51 600.5.

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

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

215.14 ~~(e) The commissioner, through the contracting process under section 256L.12, may~~
 215.15 ~~allow managed care plans and county-based purchasing plans to waive the family deductible~~
 215.16 ~~under paragraph (a), clause (5). The value of the family deductible shall not be included in~~
 215.17 ~~the capitation payment to managed care plans and county-based purchasing plans. Managed~~
 215.18 ~~care plans and county-based purchasing plans shall certify annually to the commissioner~~
 215.19 ~~the dollar value of the family deductible.~~

215.20 ~~(f)~~ (b) The commissioner shall increase adjust co-payments, coinsurance, and deductibles
 215.21 for covered services in a manner sufficient to reduce maintain the actuarial value of the
 215.22 benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to
 215.23 eligible recipients or services exempt from cost-sharing under state law. The cost-sharing
 215.24 changes described in this paragraph shall not be implemented prior to January 1, 2016.

215.25 ~~(g)~~ (c) The cost-sharing changes authorized under paragraph (f) (b) must satisfy the
 215.26 requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal
 215.27 Regulations, title 42, sections 600.510 and 600.520.

215.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

215.29 Sec. 58. Minnesota Statutes 2016, section 256L.11, is amended by adding a subdivision
 215.30 to read:

215.31 Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare
 215.32 enrollees on or after January 1, 2018, the commissioner shall increase payment rates to

216.1 dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12
216.2 shall reflect the payment increase described in this subdivision. The prepaid health plans
216.3 under contract with the commissioner shall provide payments to dental providers that are
216.4 at least equal to a rate that includes the payment rate specified in this subdivision, and if
216.5 applicable to the provider, the rates described under subdivision 7.

216.6 Sec. 59. Minnesota Statutes 2016, section 256L.11, subdivision 7, is amended to read:

216.7 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
216.8 MinnesotaCare enrollees on or after July 1, ~~2016~~ 2017, the commissioner shall increase
216.9 payment rates to dentists and dental clinics deemed by the commissioner to be critical access
216.10 providers under section 256B.76, subdivision 4, by ~~32.5~~ 20 percent above the payment rate
216.11 that would otherwise be paid to the provider, ~~except for a dental clinic or dental group~~
216.12 ~~described in section 256B.76, subdivision 4, paragraph (b), in which the commissioner shall~~
216.13 ~~increase the payment rate by 30 percent above the payment rate that would otherwise be~~
216.14 ~~paid to the provider.~~ The commissioner shall pay the prepaid health plans under contract
216.15 with the commissioner amounts sufficient to reflect this rate increase. The prepaid health
216.16 plan must pass this rate increase to providers who have been identified by the commissioner
216.17 as critical access dental providers under section 256B.76, subdivision 4.

216.18 Sec. 60. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

216.19 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner
216.20 shall establish a sliding fee scale to determine the percentage of monthly individual or family
216.21 income that households at different income levels must pay to obtain coverage through the
216.22 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly
216.23 individual or family income.

216.24 (b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according
216.25 to the premium scale specified in paragraph (d).

216.26 (c) Paragraph (b) does not apply to:

216.27 (1) children 20 years of age or younger; and

216.28 (2) individuals with household incomes below 35 percent of the federal poverty
216.29 guidelines.

216.30 (d) The following premium scale is established for each individual in the household who
216.31 is 21 years of age or older and enrolled in MinnesotaCare:

	Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
217.1			
217.2			
217.3	35%	55%	\$4
217.4	55%	80%	\$6
217.5	80%	90%	\$8
217.6	90%	100%	\$10
217.7	100%	110%	\$12
217.8	110%	120%	\$14
217.9	120%	130%	\$15
217.10	130%	140%	\$16
217.11	140%	150%	\$25
217.12	150%	160%	\$29 <u>\$37</u>
217.13	160%	170%	\$33 <u>\$44</u>
217.14	170%	180%	\$38 <u>\$52</u>
217.15	180%	190%	\$43 <u>\$61</u>
217.16	190%	<u>200%</u>	\$50 <u>\$71</u>
217.17	<u>200%</u>		<u>\$80</u>

217.18 **EFFECTIVE DATE.** This section is effective August 1, 2015.

217.19 Sec. 61. **CAPITATION PAYMENT DELAY.**

217.20 (a) The commissioner of human services shall delay the medical assistance capitation
 217.21 payment to managed care plans and county-based purchasing plans due in May 2019 until
 217.22 July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July
 217.23 31, 2019.

217.24 (b) The commissioner of human services shall delay the medical assistance capitation
 217.25 payment to managed care plans and county-based purchasing plans due in May 2021 until
 217.26 July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July
 217.27 31, 2021.

217.28 Sec. 62. **FEDERAL WAIVER OR APPROVAL; STATE PROGRAM**

217.29 **PARTICIPATION REQUIREMENT.**

217.30 The commissioner of human services shall seek any federal waiver or approval necessary
 217.31 to implement section 38.

218.1 **Sec. 63. COMPETITIVE BIDDING AND PROCUREMENT FOR CONTRACT**
218.2 **YEAR 2019.**

218.3 (a) If the commissioner of human services decides to conduct a procurement for managed
218.4 care organization contracts effective for contract year 2019, for nonelderly adults and
218.5 children who are not eligible on the basis of a disability and are enrolled in medical assistance
218.6 or MinnesotaCare, the commissioner shall utilize a competitive price and technical bidding
218.7 process that meets the requirements described under this section. For purposes of this section,
218.8 "managed care organization" means a demonstration provider as defined in Minnesota
218.9 Statutes, section 256B.69, subdivision 2, paragraph (b).

218.10 (b) The commissioner shall not procure through a statewide procurement which includes
218.11 all 87 counties, but shall establish geographic regions for the purpose of procurement. No
218.12 geographic region shall exceed 60 percent of the total enrollment to which this section
218.13 applies, except in cases when a managed care organization withdraws from their contract
218.14 with the state, managed care organizations merge, other significant market changes occur
218.15 within the purchasing or health care delivery system, or counties within the proposed
218.16 geographic region agree to a larger procurement. The commissioner shall ensure that there
218.17 is an adequate choice of managed care organizations based on the potential enrollment. The
218.18 commissioner shall operate the competitive bidding program by region, but shall award
218.19 contracts by county and shall allow managed care organizations with a service area consisting
218.20 of only a portion of a region to only bid on those counties within their licensed service area.

218.21 (c) The commissioner shall provide the scoring weight of selection criteria to be assigned
218.22 in the competitive bidding procurement process and include the scoring weight in the request
218.23 for proposals. Substantial weight shall be given to county board resolutions and priority
218.24 areas identified by counties, when that input meets federal requirements under Code of
218.25 Federal Regulations, title 42, part 338.58.

218.26 (d) If a best and final offer is requested, each responding managed care organization
218.27 must be offered the opportunity to submit a best and final offer.

218.28 (e) The commissioner, when evaluating proposals, shall consider network adequacy for
218.29 dental and other services.

218.30 (f) After the managed care organizations are notified about the award determination,
218.31 but before contracts are signed, the commissioner shall meet with any responder upon
218.32 request to discuss their individual results in detail. No evaluation materials will be provided
218.33 in writing until final contracts are signed.

219.1 (g) The commissioner shall provide information to potential responders that outlines the
219.2 goals and objectives of the procurement, in advance of any publication of a request for
219.3 proposals under this section.

219.4 (h) A managed care organization that is aggrieved by the commissioner's decision related
219.5 to the selection of managed care organizations to deliver services in a county or counties
219.6 may appeal the commissioner's decision using the process outlined in Minnesota Statutes,
219.7 section 256B.69, subdivision 3a, paragraph (d).

219.8 (i) Any procurement conducted by the commissioner before January 1, 2019, must meet
219.9 the requirements of this section, and a new procurement shall not be conducted for at least
219.10 three years within the geographic regions included, except in cases where a managed care
219.11 organization withdraws from the contract with the state, managed care organizations merge,
219.12 or other significant market changes occur within the purchasing or health care delivery
219.13 system, or counties within the geographic region agree to a shorter procurement time period.

219.14 **Sec. 64. OPIOID USE AND ACUPUNCTURE STUDY.**

219.15 (a) The commissioner of human services, within the limits of available appropriations,
219.16 shall study the use of opiates for the treatment of chronic pain conditions when acupuncture
219.17 services are also part of the treatment for chronic pain as compared to opiate use among
219.18 medical assistance recipients who are not receiving acupuncture. In comparing the sample
219.19 groups, the commissioner shall look at each group's opiate use and other services as identified
219.20 by the commissioner.

219.21 (b) The aggregate findings of the study shall be submitted by the commissioner to the
219.22 chairs and ranking minority members of the legislative committees with jurisdiction over
219.23 health and human services policy and finance by February 15, 2018. The report shall not
219.24 contain or disclose any patient identifying data.

219.25 **Sec. 65. STUDY OF PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT**
219.26 **AND SUPPLIES.**

219.27 The commissioner of human services shall study the impact of basing medical assistance
219.28 payment for durable medical equipment and medical supplies on Medicare payment rates,
219.29 as limited by the payment provisions in the 21st Century Cures Act, Public Law 114-255,
219.30 on access by medical assistance enrollees to these items. The study must include
219.31 recommendations for ensuring and improving access by medical assistance enrollees to
219.32 durable medical equipment and medical supplies. The commissioner shall report study
219.33 results and recommendations to the chairs and ranking minority members of the legislative

220.1 committees with jurisdiction over health and human services policy and finance by January
 220.2 1, 2019.

220.3 Sec. 66. **ELIGIBILITY VERIFICATION FEDERAL COMPLIANCE.**

220.4 The commissioner of human services shall implement a process to terminate coverage
 220.5 for medical assistance enrollees who fail to submit requested verifications within 95 days
 220.6 of coverage approval. The commissioner shall implement a manual process by July 1, 2017,
 220.7 with the counties and tribal agencies, and provide them with instructions and necessary
 220.8 reports. The commissioner shall ensure that the Minnesota eligibility technology system
 220.9 (METS) has the required functionality to implement an automated process to verify eligibility
 220.10 by April 1, 2018.

220.11 Sec. 67. **REVISOR'S INSTRUCTION.**

220.12 The revisor of statutes, in the next edition of Minnesota Statutes, shall change the term
 220.13 "health care delivery system" and similar terms to "integrated health partnership" and similar
 220.14 terms, wherever it appears in Minnesota Statutes, section 256B.0755.

220.15 Sec. 68. **REPEALER.**

220.16 (a) Minnesota Statutes 2016, sections 256B.19, subdivision 1c; and 256B.64, are repealed.

220.17 (b) Minnesota Rules, part 9500.1140, subparts 3, 4, 5, and 6, are repealed.

220.18 **ARTICLE 5**

220.19 **HEALTH INSURANCE**

220.20 Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

220.21 Subdivision 1. **Reference.** (a) Any reference to "standard provisions" which may appear
 220.22 in other sections and which refer to accident and sickness or accident and health insurance
 220.23 shall hereinafter be construed as referring to accident and sickness policy provisions.

220.24 (b) Notwithstanding paragraph (a), the following do not apply to health plans:

220.25 (1) subdivision 2, clauses (5) to (10) and (12);

220.26 (2) subdivision 3, clauses (1) and (3) to (7); and

220.27 (3) subdivisions 6 and 10.

220.28 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 220.29 renewed on or after January 1, 2018.

221.1 Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

221.2 Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain
221.3 a provision which permits continuation of coverage under the policy for the insured's ~~former~~
221.4 ~~spouse and dependent children upon~~, which is defined as required by section 62A.302, and
221.5 former spouse, who was covered on the day before the entry of a valid decree of dissolution
221.6 of marriage. The coverage shall be continued until the earlier of the following dates:

221.7 (a) the date the insured's former spouse becomes covered under any other group health
221.8 plan; or

221.9 (b) the date coverage would otherwise terminate under the policy.

221.10 If the coverage is provided under a group policy, any required premium contributions
221.11 for the coverage shall be paid by the insured on a monthly basis to the group policyholder
221.12 for remittance to the insurer. The policy must require the group policyholder to, upon request,
221.13 provide the insured with written verification from the insurer of the cost of this coverage
221.14 promptly at the time of eligibility for this coverage and at any time during the continuation
221.15 period. In no event shall the amount of premium charged exceed 102 percent of the cost to
221.16 the plan for such period of coverage for other similarly situated spouses and dependent
221.17 children with respect to whom the marital relationship has not dissolved, without regard to
221.18 whether such cost is paid by the employer or employee.

221.19 Upon request by the insured's former spouse, who was covered on the day before the
221.20 entry of a valid decree of dissolution, or dependent child, a health carrier must provide the
221.21 instructions necessary to enable the child or former spouse to elect continuation of coverage.

221.22 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
221.23 renewed on or after January 1, 2018.

221.24 Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

221.25 **62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.**

221.26 (a) A health plan company that provides coverage under a health plan for cancer
221.27 chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance
221.28 amount for a prescribed, orally administered anticancer medication that is used to kill or
221.29 slow the growth of cancerous cells than what the health plan requires for an intravenously
221.30 administered or injected cancer medication that is provided, regardless of formulation or
221.31 benefit category determination by the health plan company.

222.1 (b) A health plan company must not achieve compliance with this section by imposing
222.2 an increase in co-payment, deductible, or coinsurance amount for an intravenously
222.3 administered or injected cancer chemotherapy agent covered under the health plan.

222.4 (c) Nothing in this section shall be interpreted to prohibit a health plan company from
222.5 requiring prior authorization or imposing other appropriate utilization controls in approving
222.6 coverage for any chemotherapy.

222.7 (d) A plan offered by the commissioner of management and budget under section 43A.23
222.8 is deemed to be at parity and in compliance with this section.

222.9 (e) A health plan company is in compliance with this section if it does not include orally
222.10 administered anticancer medication in the fourth tier of its pharmacy benefit.

222.11 (f) A health plan company that provides coverage under a health plan for cancer
222.12 chemotherapy treatment must indicate the level of coverage for orally administered anticancer
222.13 medication within its pharmacy benefit filing with the commissioner.

222.14 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to health
222.15 plans offered, sold, issued, or renewed on or after that date.

222.16 Sec. 4. Minnesota Statutes 2016, section 62D.105, is amended to read:

222.17 **62D.105 COVERAGE OF CURRENT SPOUSE, FORMER SPOUSE, AND**
222.18 **CHILDREN.**

222.19 Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to
222.20 covering the enrollee also provides coverage to the spouse ~~and~~, dependent children, which
222.21 is defined as required by section 62A.302, and former spouse who was covered on the day
222.22 before the entry of a valid decree of dissolution of marriage, of the enrollee shall: (1) permit
222.23 the spouse, former spouse, and dependent children to elect to continue coverage when the
222.24 enrollee becomes enrolled for benefits under title XVIII of the Social Security Act
222.25 (Medicare); and (2) permit the dependent children to continue coverage when they cease
222.26 to be dependent children under the generally applicable requirement of the plan.

222.27 Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be
222.28 continued until the earlier of the following dates:

222.29 (1) the date coverage would otherwise terminate under the contract;

222.30 (2) 36 months after continuation by the spouse, former spouse, or dependent was elected;

222.31 or

223.1 (3) the date the spouse, former spouse, or dependent children become covered under
223.2 another group health plan or Medicare.

223.3 If coverage is provided under a group policy, any required fees for the coverage shall
223.4 be paid by the enrollee on a monthly basis to the group contract holder for remittance to the
223.5 health maintenance organization. In no event shall the fee charged exceed 102 percent of
223.6 the cost to the plan for such coverage for other similarly situated spouse and dependent
223.7 children to whom subdivision 1 is not applicable, without regard to whether such cost is
223.8 paid by the employer or employee.

223.9 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
223.10 renewed on or after January 1, 2018.

223.11 Sec. 5. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

223.12 Subd. 11. ~~Essential health benefits package~~ **Affordable Care Act compliant plans.**
223.13 ~~For individual or small group health plans that include the essential health benefits package~~
223.14 ~~and are any policy of accident and health insurance subject to the requirements of the~~
223.15 Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold,
223.16 issued, or renewed on or after January 1, 2014 2018, the requirements of this section do not
223.17 apply.

223.18 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
223.19 renewed on or after January 1, 2018.

223.20 Sec. 6. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

223.21 Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for
223.22 certification of a plan of health coverage as a qualified plan or a qualified Medicare
223.23 supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall
223.24 make a determination within 90 days as to whether the plan is qualified. All plans of health
223.25 coverage, except Medicare supplement policies, shall be labeled as "qualified" or
223.26 "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified
223.27 plans shall indicate whether they are number one, two, or three coverage plans. For any
223.28 policy of accident and health insurance subject to the requirements of the Affordable Care
223.29 Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or
223.30 renewed on or after January 1, 2018, the requirements of this section do not apply.

223.31 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
223.32 renewed on or after January 1, 2018.

224.1 Sec. 7. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to
224.2 read:

224.3 Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health
224.4 insurance subject to the requirements of the Affordable Care Act, as defined under section
224.5 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1,
224.6 2018, the requirements of this section do not apply.

224.7 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
224.8 renewed on or after January 1, 2018.

224.9 Sec. 8. Laws 2017, chapter 2, article 1, section 5, is amended to read:

224.10 Sec. 5. **SUNSET.**

224.11 This article ~~sunsets June 30,~~ other than section 2, subdivision 5; section 3; and section
224.12 7, sunsets August 31, 2018.

224.13 Sec. 9. Laws 2017, chapter 2, article 1, section 7, is amended to read:

224.14 Sec. 7. **APPROPRIATIONS.**

224.15 (a) \$311,788,000 in fiscal year 2017 is appropriated from the general fund to the
224.16 commissioner of management and budget for premium assistance under section 2. This
224.17 appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

224.18 (b) \$157,000 in fiscal year 2017 is appropriated from the general fund to the legislative
224.19 auditor for purposes of section 3. This appropriation is onetime.

224.20 (c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018,
224.21 shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the
224.22 budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

224.23 Sec. 10. Laws 2017, chapter 13, article 1, section 15, is amended to read:

224.24 Sec. 15. **MINNESOTA PREMIUM SECURITY PLAN FUNDING.**

224.25 (a) The Minnesota Comprehensive Health Association shall fund the operational and
224.26 administrative costs and reinsurance payments of the Minnesota security plan and association
224.27 using the following amounts deposited in the premium security plan account in Minnesota
224.28 Statutes, section 62E.25, subdivision 1, in the following order:

224.29 (1) any federal funding available;

224.30 (2) funds deposited under article 1, sections 12 and 13;

225.1 (3) any state funds from the health care access fund; and

225.2 (4) any state funds from the general fund.

225.3 (b) The association shall transfer from the premium security plan account any ~~general~~
 225.4 ~~fund amount~~ state funds not used for the Minnesota premium security plan by June 30,
 225.5 2021, to the commissioner of commerce. Any amount transferred to the commissioner of
 225.6 commerce shall be deposited in the ~~general fund~~.

225.7 ~~(e) The association shall transfer from the premium security plan account any health~~
 225.8 ~~care access fund amount not used for the Minnesota premium security plan by June 30,~~
 225.9 ~~2021, to the commissioner of commerce. Any amount transferred to the commissioner of~~
 225.10 ~~commerce shall be deposited in the~~ health care access fund in Minnesota Statutes, section
 225.11 16A.724.

225.12 ~~(d)~~ (c) The Minnesota Comprehensive Health Association may not spend more than
 225.13 \$271,000,000 for benefit year 2018 and not more than \$271,000,000 for benefit year 2019
 225.14 for the operational and administrative costs of, and reinsurance payments under, the
 225.15 Minnesota premium security plan.

225.16 Sec. 11. MORATORIUM ON CONVERSION TRANSACTIONS.

225.17 (a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit health service plan
 225.18 corporation operating under Minnesota Statutes, chapter 62C, or health maintenance
 225.19 organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may
 225.20 only merge or consolidate with; or convert, or transfer all or a substantial portion of its
 225.21 assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A.

225.22 (b) Paragraph (a) does not apply if the service plan corporation or health maintenance
 225.23 organization files an intent to dissolve due to insolvency of the corporation in accordance
 225.24 with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under
 225.25 Minnesota Statutes, chapter 60B.

225.26 (c) Nothing in this section shall be construed to authorize a health maintenance
 225.27 organization or a nonprofit health service plan corporation to engage in any transaction or
 225.28 activities not otherwise permitted under state law.

225.29 (d) This section expires July 1, 2019.

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

226.1 **ARTICLE 6**

226.2 **DIRECT CARE AND TREATMENT**

226.3 Section 1. Minnesota Statutes 2016, section 252.50, subdivision 5, is amended to read:

226.4 Subd. 5. **Location of programs.** (a) In determining the location of state-operated,
226.5 community-based programs, the needs of the individual client shall be paramount. The
226.6 commissioner shall also take into account:

226.7 (1) prioritization of beds in state-operated, community-based programs for individuals
226.8 with complex behavioral needs that cannot be met by private community-based providers;

226.9 (2) choices made by individuals who chose to move to a more integrated setting, and
226.10 shall coordinate with the lead agency to ensure that appropriate person-centered transition
226.11 plans are created;

226.12 (3) the personal preferences of the persons being served and their families as determined
226.13 by Minnesota Rules, parts 9525.0004 to 9525.0036;

226.14 ~~(2)~~ (4) the location of the support services established by the individual service plans of
226.15 the persons being served;

226.16 ~~(3)~~ (5) the appropriate grouping of the persons served;

226.17 ~~(4)~~ (6) the availability of qualified staff;

226.18 ~~(5)~~ (7) the need for state-operated, community-based programs in the geographical region
226.19 of the state; and

226.20 ~~(6)~~ (8) a reasonable commuting distance from a regional treatment center or the residences
226.21 of the program staff.

226.22 (b) State-operated, community-based programs must be located according to section
226.23 252.28.

226.24 Sec. 2. Minnesota Statutes 2016, section 253B.10, subdivision 1, is amended to read:

226.25 Subdivision 1. **Administrative requirements.** (a) When a person is committed, the
226.26 court shall issue a warrant or an order committing the patient to the custody of the head of
226.27 the treatment facility. The warrant or order shall state that the patient meets the statutory
226.28 criteria for civil commitment.

226.29 (b) The commissioner shall prioritize patients being admitted from jail or a correctional
226.30 institution who are:

227.1 (1) ordered confined in a state hospital for an examination under Minnesota Rules of
227.2 Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

227.3 (2) under civil commitment for competency treatment and continuing supervision under
227.4 Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

227.5 (3) found not guilty by reason of mental illness under Minnesota Rules of Criminal
227.6 Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be
227.7 detained in a state hospital or other facility pending completion of the civil commitment
227.8 proceedings; or

227.9 (4) committed under this chapter to the commissioner after dismissal of the patient's
227.10 criminal charges.

227.11 Patients described in this paragraph must be admitted to a service operated by the
227.12 commissioner within 48 hours. The commitment must be ordered by the court as provided
227.13 in section 253B.09, subdivision 1, paragraph (c).

227.14 (c) Upon the arrival of a patient at the designated treatment facility, the head of the
227.15 facility shall retain the duplicate of the warrant and endorse receipt upon the original warrant
227.16 or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed
227.17 in the court of commitment. After arrival, the patient shall be under the control and custody
227.18 of the head of the treatment facility.

227.19 (d) Copies of the petition for commitment, the court's findings of fact and conclusions
227.20 of law, the court order committing the patient, the report of the examiners, and the prepetition
227.21 report shall be provided promptly to the treatment facility. This information shall also be
227.22 provided by the head of the treatment facility to treatment facility staff in a consistent and
227.23 timely manner and pursuant to all applicable laws.

227.24 Sec. 3. **REVIEW OF ALTERNATIVES TO STATE-OPERATED GROUP HOMES**
227.25 **HOUSING ONE PERSON.**

227.26 The commissioner of human services shall review the potential for, and the viability of,
227.27 alternatives to state-operated group homes housing one person. The intent is to create housing
227.28 options for individuals who do not belong in an institutionalized setting, but need additional
227.29 support before transitioning to a more independent community placement. The review shall
227.30 include an analysis of existing housing settings operated by counties and private providers,
227.31 as well as the potential for new housing settings, and determine the viability for use by
227.32 state-operated services. The commissioner shall seek input from interested stakeholders as
227.33 part of the review. An update, including alternatives identified, will be provided by the

228.1 commissioner to the members of the legislative committees having jurisdiction over human
228.2 services issues no later than January 15, 2018.

228.3 **ARTICLE 7**

228.4 **CHILDREN AND FAMILIES**

228.5 Section 1. Minnesota Statutes 2016, section 13.32, is amended by adding a subdivision
228.6 to read:

228.7 Subd. 12. **Access by welfare system.** County personnel in the welfare system may
228.8 request access to education data in order to coordinate services for a student or family. The
228.9 request must be submitted to the chief administrative officer of the school and must include
228.10 the basis for the request and a description of the information that is requested. The chief
228.11 administrative officer must provide a copy of the request to the parent or legal guardian of
228.12 the student who is the subject of the request, along with a form the parent or legal guardian
228.13 may execute to consent to the release of specified information to the requester. Education
228.14 data may be released under this subdivision only if the parent or legal guardian gives
228.15 informed consent to the release.

228.16 Sec. 2. Minnesota Statutes 2016, section 13.46, subdivision 1, is amended to read:

228.17 Subdivision 1. **Definitions.** As used in this section:

228.18 (a) "Individual" means an individual according to section 13.02, subdivision 8, but does
228.19 not include a vendor of services.

228.20 (b) "Program" includes all programs for which authority is vested in a component of the
228.21 welfare system according to statute or federal law, including, but not limited to, Native
228.22 American tribe programs that provide a service component of the welfare system, the aid
228.23 to families with dependent children program formerly codified in sections 256.72 to 256.87,
228.24 Minnesota family investment program, temporary assistance for needy families program,
228.25 medical assistance, general assistance, general assistance medical care formerly codified in
228.26 chapter 256D, child care assistance program, and child support collections.

228.27 (c) "Welfare system" includes the Department of Human Services, local social services
228.28 agencies, county welfare agencies, county public health agencies, county veteran services
228.29 agencies, county housing agencies, private licensing agencies, the public authority responsible
228.30 for child support enforcement, human services boards, community mental health center
228.31 boards, state hospitals, state nursing homes, the ombudsman for mental health and
228.32 developmental disabilities, Native American tribes to the extent a tribe provides a service

229.1 component of the welfare system, and persons, agencies, institutions, organizations, and
229.2 other entities under contract to any of the above agencies to the extent specified in the
229.3 contract.

229.4 (d) "Mental health data" means data on individual clients and patients of community
229.5 mental health centers, established under section 245.62, mental health divisions of counties
229.6 and other providers under contract to deliver mental health services, or the ombudsman for
229.7 mental health and developmental disabilities.

229.8 (e) "Fugitive felon" means a person who has been convicted of a felony and who has
229.9 escaped from confinement or violated the terms of probation or parole for that offense.

229.10 (f) "Private licensing agency" means an agency licensed by the commissioner of human
229.11 services under chapter 245A to perform the duties under section 245A.16.

229.12 Sec. 3. Minnesota Statutes 2016, section 13.46, subdivision 2, is amended to read:

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

229.15 (1) according to section 13.05;

229.16 (2) according to court order;

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

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

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

229.27 (6) to administer federal funds or programs;

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

229.29 (8) to the Department of Revenue to assess parental contribution amounts for purposes
229.30 of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs
229.31 and to identify individuals who may benefit from these programs. The following information

230.1 may be disclosed under this paragraph: an individual's and their dependent's names, dates
230.2 of birth, Social Security numbers, income, addresses, and other data as required, upon
230.3 request by the Department of Revenue. Disclosures by the commissioner of revenue to the
230.4 commissioner of human services for the purposes described in this clause are governed by
230.5 section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited
230.6 to, the dependent care credit under section 290.067, the Minnesota working family credit
230.7 under section 290.0671, the property tax refund and rental credit under section 290A.04,
230.8 and the Minnesota education credit under section 290.0674;

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

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

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

230.16 (iii) to monitor and evaluate the Minnesota family investment program or the child care
230.17 assistance program by exchanging data on recipients and former recipients of food support,
230.18 cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter
230.19 119B, medical programs under chapter 256B or 256L, or a medical program formerly
230.20 codified under chapter 256D; and

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

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

230.31 (11) data maintained by residential programs as defined in section 245A.02 may be
230.32 disclosed to the protection and advocacy system established in this state according to Part
230.33 C of Public Law 98-527 to protect the legal and human rights of persons with developmental
230.34 disabilities or other related conditions who live in residential facilities for these persons if

231.1 the protection and advocacy system receives a complaint by or on behalf of that person and
231.2 the person does not have a legal guardian or the state or a designee of the state is the legal
231.3 guardian of the person;

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

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

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

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

231.16 (i) the participant:

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

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

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

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

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

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

231.31 (18) the address, Social Security number, and, if available, photograph of any member
231.32 of a household receiving food support shall be made available, on request, to a local, state,

232.1 or federal law enforcement officer if the officer furnishes the agency with the name of the
232.2 member and notifies the agency that:

232.3 (i) the member:

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

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

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

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

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

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

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

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

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

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

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

233.6 (25) to other state agencies, statewide systems, and political subdivisions of this state,
233.7 including the attorney general, and agencies of other states, interstate information networks,
233.8 federal agencies, and other entities as required by federal regulation or law for the
233.9 administration of the child support enforcement program;

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

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

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

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

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

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

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

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

234.7 (b) Information on persons who have been treated for drug or alcohol abuse may only
234.8 be disclosed according to the requirements of Code of Federal Regulations, title 42, sections
234.9 2.1 to 2.67.

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

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

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

234.18 Sec. 4. Minnesota Statutes 2016, section 13.84, subdivision 5, is amended to read:

234.19 Subd. 5. **Disclosure.** Private or confidential court services data shall not be disclosed
234.20 except:

234.21 (a) pursuant to section 13.05;

234.22 (b) pursuant to a statute specifically authorizing disclosure of court services data;

234.23 (c) with the written permission of the source of confidential data;

234.24 (d) to the court services department, parole or probation authority or state or local
234.25 correctional agency or facility having statutorily granted supervision over the individual
234.26 subject of the data, or to county personnel within the welfare system;

234.27 (e) pursuant to subdivision 6;

234.28 (f) pursuant to a valid court order; or

234.29 (g) pursuant to section 611A.06, subdivision 3a.

235.1 Sec. 5. Minnesota Statutes 2016, section 119B.011, subdivision 20, is amended to read:

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

235.12 **EFFECTIVE DATE.** This section is effective October 23, 2017.

235.13 Sec. 6. Minnesota Statutes 2016, section 119B.011, subdivision 20a, is amended to read:

235.14 Subd. 20a. **Transition year extension families.** "Transition year extension families"
235.15 means families who have completed their transition year of child care assistance under this
235.16 subdivision and who are eligible for, but on a waiting list for, services under section 119B.03.
235.17 For purposes of sections 119B.03, subdivision 3, and 119B.05, subdivision 1, clause (2),
235.18 families participating in extended transition year shall not be considered transition year
235.19 families. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090,
235.20 subpart 2, transition year extension child care may be used to support employment, approved
235.21 education or training programs, or a job search that meets the requirements of section
235.22 119B.10 for the length of time necessary for families to be moved from the basic sliding
235.23 fee waiting list into the basic sliding fee program.

235.24 **EFFECTIVE DATE.** This section is effective October 23, 2017.

235.25 Sec. 7. Minnesota Statutes 2016, section 119B.025, subdivision 1, is amended to read:

235.26 Subdivision 1. ~~Factors which must be verified~~ **Applications.** (a) The county shall
235.27 verify the following at all initial child care applications using the universal application:

235.28 (1) identity of adults;

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

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

- 236.1 (4) age;
- 236.2 (5) immigration status, if related to eligibility;
- 236.3 (6) Social Security number, if given;
- 236.4 (7) counted income;
- 236.5 (8) spousal support and child support payments made to persons outside the household;
- 236.6 (9) residence; and
- 236.7 (10) inconsistent information, if related to eligibility.

236.8 (b) ~~If a family did not use the universal application or child care addendum to apply for~~
236.9 ~~child care assistance, the family must complete the universal application or child care~~
236.10 ~~addendum at its next eligibility redetermination and the county must verify the factors listed~~
236.11 ~~in paragraph (a) as part of that redetermination. Once a family has completed a universal~~
236.12 ~~application or child care addendum, the county shall use the redetermination form described~~
236.13 ~~in paragraph (c) for that family's subsequent redeterminations. Eligibility must be~~
236.14 ~~redetermined at least every six months. A family is considered to have met the eligibility~~
236.15 ~~redetermination requirement if a complete redetermination form and all required verifications~~
236.16 ~~are received within 30 days after the date the form was due. When the 30th day after the~~
236.17 ~~date the form was due falls on a Saturday, Sunday, or legal holiday, the 30-day time period~~
236.18 ~~is extended to include the next succeeding day that is not a Saturday, Sunday, or legal~~
236.19 ~~holiday. Assistance shall be payable retroactively from the redetermination due date. For a~~
236.20 ~~family where at least one parent is under the age of 21, does not have a high school or~~
236.21 ~~general equivalency diploma, and is a student in a school district or another similar program~~
236.22 ~~that provides or arranges for child care, as well as parenting, social services, career and~~
236.23 ~~employment supports, and academic support to achieve high school graduation, the~~
236.24 ~~redetermination of eligibility shall be deferred beyond six months, but not to exceed 12~~
236.25 ~~months, to the end of the student's school year. If a family reports a change in an eligibility~~
236.26 ~~factor before the family's next regularly scheduled redetermination, the county must~~
236.27 ~~recalculate eligibility without requiring verification of any eligibility factor that did not~~
236.28 ~~change. Changes must be reported as required by section 256P.07. A change in income~~
236.29 ~~occurs on the day the participant received the first payment reflecting the change in income.~~
236.30 The county must mail a notice of approval or denial of assistance to the applicant within
236.31 30 calendar days after receiving the application. The county may extend the response time
236.32 by 15 calendar days if the applicant is informed of the extension.

237.1 ~~(e) The commissioner shall develop a redetermination form to redetermine eligibility~~
237.2 ~~and a change report form to report changes that minimize paperwork for the county and the~~
237.3 ~~participant.~~

237.4 **EFFECTIVE DATE.** This section is effective October 23, 2017.

237.5 Sec. 8. Minnesota Statutes 2016, section 119B.025, is amended by adding a subdivision
237.6 to read:

237.7 Subd. 3. **Redeterminations.** (a) Notwithstanding Minnesota Rules, part 3400.0180, item
237.8 A, the county shall conduct a redetermination according to paragraphs (b) and (c).

237.9 (b) The county shall use the redetermination form developed by the commissioner. The
237.10 county must verify the factors listed in subdivision 1, paragraph (a), as part of the
237.11 redetermination.

237.12 (c) An applicant's eligibility must be redetermined no more frequently than every 12
237.13 months. The following criteria apply:

237.14 (1) a family meets the eligibility redetermination requirements if a complete
237.15 redetermination form and all required verifications are received within 30 days after the
237.16 date the form was due;

237.17 (2) if the 30th day after the date the form was due falls on a Saturday, Sunday, or holiday,
237.18 the 30-day time period is extended to include the next day that is not a Saturday, Sunday,
237.19 or holiday. Assistance shall be payable retroactively from the redetermination due date;

237.20 (3) for a family where at least one parent is younger than 21 years of age, does not have
237.21 a high school degree or general equivalency diploma, and is a student in a school district
237.22 or another similar program that provides or arranges for child care, parenting, social services,
237.23 career and employment supports, and academic support to achieve high school graduation,
237.24 the redetermination of eligibility may be deferred beyond 12 months, to the end of the
237.25 student's school year; and

237.26 (4) a family and the family's providers must be notified that the family's redetermination
237.27 is due at least 45 days before the end of the family's 12-month eligibility period.

237.28 **EFFECTIVE DATE.** This section is effective October 23, 2017.

238.1 Sec. 9. Minnesota Statutes 2016, section 119B.025, is amended by adding a subdivision
238.2 to read:

238.3 Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility
238.4 factors according to paragraphs (b) to (g).

238.5 (b) A family is subject to the reporting requirements in section 256P.07.

238.6 (c) If a family reports a change or a change is known to the agency before the family's
238.7 regularly scheduled redetermination, the county must act on the change. The commissioner
238.8 shall establish standards for verifying a change.

238.9 (d) A change in income occurs on the day the participant received the first payment
238.10 reflecting the change in income.

238.11 (e) During a family's 12-month eligibility period, if the family's income increases and
238.12 remains at or below 85 percent of the state median income, adjusted for family size, there
238.13 is no change to the family's eligibility. The county shall not request verification of the
238.14 change. The co-payment fee shall not increase during the remaining portion of the family's
238.15 12-month eligibility period.

238.16 (f) During a family's 12-month eligibility period, if the family's income increases and
238.17 exceeds 85 percent of the state median income, adjusted for family size, the family is not
238.18 eligible for child care assistance. The family must be given 15 calendar days to provide
238.19 verification of the change. If the required verification is not returned or confirms ineligibility,
238.20 the family's eligibility ends following a subsequent 15-day adverse action notice.

238.21 (g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170,
238.22 subpart 1, if an applicant or participant reports that employment ended, the agency may
238.23 accept a signed statement from the applicant or participant as verification that employment
238.24 ended.

238.25 **EFFECTIVE DATE.** Paragraphs (a) and (b) are effective the day following final
238.26 enactment. Paragraphs (c) to (g) are effective October 23, 2017.

238.27 Sec. 10. Minnesota Statutes 2016, section 119B.03, subdivision 3, is amended to read:

238.28 Subd. 3. **Eligible participants.** Families that meet the eligibility requirements under
238.29 sections ~~119B.07~~, 119B.09, and 119B.10, except MFIP participants, diversionary work
238.30 program, and transition year families are eligible for child care assistance under the basic
238.31 sliding fee program. Families enrolled in the basic sliding fee program shall be continued

239.1 until they are no longer eligible. Child care assistance provided through the child care fund
239.2 is considered assistance to the parent.

239.3 **EFFECTIVE DATE.** This section is effective December 18, 2017.

239.4 Sec. 11. Minnesota Statutes 2016, section 119B.05, subdivision 1, is amended to read:

239.5 Subdivision 1. **Eligible participants.** Families eligible for child care assistance under
239.6 the MFIP child care program are:

239.7 (1) MFIP participants who are employed or in job search and meet the requirements of
239.8 section 119B.10;

239.9 (2) persons who are members of transition year families under section 119B.011,
239.10 subdivision 20, and meet the requirements of section 119B.10;

239.11 (3) families who are participating in employment orientation or job search, or other
239.12 employment or training activities that are included in an approved employability development
239.13 plan under section 256J.95;

239.14 (4) MFIP families who are participating in work job search, job support, employment,
239.15 or training activities as required in their employment plan, or in appeals, hearings,
239.16 assessments, or orientations according to chapter 256J;

239.17 (5) MFIP families who are participating in social services activities under chapter 256J
239.18 as required in their employment plan approved according to chapter 256J;

239.19 (6) families who are participating in services or activities that are included in an approved
239.20 family stabilization plan under section 256J.575;

239.21 (7) families who are participating in programs as required in tribal contracts under section
239.22 119B.02, subdivision 2, or 256.01, subdivision 2;

239.23 (8) families who are participating in the transition year extension under section 119B.011,
239.24 subdivision 20a; ~~and~~

239.25 (9) student parents as defined under section 119B.011, subdivision 19b; and

239.26 (10) student parents who turn 21 years of age and who continue to meet the other
239.27 requirements under section 119B.011, subdivision 19b. A student parent continues to be
239.28 eligible until the student parent is approved for basic sliding fee child care assistance or
239.29 until the student parent's redetermination, whichever comes first. At the student parent's
239.30 redetermination, if the student parent was not approved for basic sliding fee child care
239.31 assistance, a student parent's eligibility ends following a 15-day adverse action notice.

240.1 **EFFECTIVE DATE.** This section is effective October 23, 2017.

240.2 Sec. 12. Minnesota Statutes 2016, section 119B.09, subdivision 1, is amended to read:

240.3 Subdivision 1. **General eligibility requirements for all applicants for child care**

240.4 **assistance.** (a) Child care services must be available to families who need child care to find
240.5 or keep employment or to obtain the training or education necessary to find employment
240.6 and who:

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

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

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

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

240.21 (d) All applicants for child care assistance and families currently receiving child care
240.22 assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition
240.23 of eligibility. The co-payment fee may include additional recoupment fees due to a child
240.24 care assistance program overpayment.

240.25 **EFFECTIVE DATE.** Paragraphs (a) and (c) are effective October 23, 2017. Paragraph
240.26 (d) is effective the day following final enactment.

240.27 Sec. 13. Minnesota Statutes 2016, section 119B.09, subdivision 4, is amended to read:

240.28 Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant
240.29 family is the current monthly income of the family multiplied by 12 or the income for the
240.30 12-month period immediately preceding the date of application, or income calculated by
240.31 the method which provides the most accurate assessment of income available to the family.

241.1 (b) Self-employment income must be calculated based on gross receipts less operating
 241.2 expenses. Income must be recalculated when the family's income changes, but no less often
 241.3 than every six months. For a family where at least one parent is under the age of 21, does
 241.4 not have a high school or general equivalency diploma, and is a student in a school district
 241.5 or another similar program that provides or arranges for child care, as well as parenting,
 241.6 social services, career and employment supports, and academic support to achieve high
 241.7 school graduation, income must be recalculated when the family's income changes, but
 241.8 otherwise shall be deferred beyond six months, but not to exceed 12 months, to the end of
 241.9 the student's school year.

241.10 (c) Income changes are processed under section 119B.025, subdivision 4. Included lump
 241.11 sums counted as income under section 256P.06, subdivision 3, must be annualized over 12
 241.12 months. Income must be verified with documentary evidence. If the applicant does not have
 241.13 sufficient evidence of income, verification must be obtained from the source of the income.

241.14 **EFFECTIVE DATE.** This section is effective October 23, 2017.

241.15 Sec. 14. **[119B.095] CHILD CARE AUTHORIZATIONS.**

241.16 Subdivision 1. **General authorization requirements.** (a) When authorizing the amount
 241.17 of child care, the county agency must consider the amount of time the parent reports on the
 241.18 application or redetermination form that the child attends preschool, a Head Start program,
 241.19 or school while the parent is participating in an authorized activity.

241.20 (b) Care must be authorized and scheduled with a provider based on the applicant's or
 241.21 participant's verified activity schedule when:

241.22 (1) the family requests care from more than one provider per child;

241.23 (2) the family requests care from a legal nonlicensed provider; or

241.24 (3) an applicant or participant is employed by any child care center that is licensed by
 241.25 the Department of Human Services or has been identified as a high-risk Medicaid-enrolled
 241.26 provider.

241.27 (c) If the family remains eligible at redetermination, a new authorization with fewer
 241.28 hours, the same hours, or increased hours may be determined.

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

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

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

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

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

242.11 (1) the child's school schedule;

242.12 (2) the custody schedule; or

242.13 (3) the provider's availability.

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

242.17 **EFFECTIVE DATE.** This section is effective December 18, 2017.

242.18 **Sec. 15. [119B.097] AUTHORIZATION WITH A SECONDARY PROVIDER.**

242.19 (a) If a child uses any combination of the following providers paid by child care
 242.20 assistance, a parent must choose one primary provider and one secondary provider per child
 242.21 that can be paid by child care assistance:

242.22 (1) an individual or child care center licensed under chapter 245A;

242.23 (2) an individual or child care center or facility holding a valid child care license issued
 242.24 by another state or tribe; or

242.25 (3) a child care center exempt from licensing under section 245A.03.

242.26 (b) The amount of child care authorized with the secondary provider cannot exceed 20
 242.27 hours per two-week service period, per child, and the amount of care paid to a child's
 242.28 secondary provider is limited under section 119B.13, subdivision 1. The total amount of
 242.29 child care authorized with both the primary and secondary provider cannot exceed the
 242.30 amount of child care allowed based on the parents' eligible activity schedule, the child's
 242.31 school schedule, and any other factors relevant to the family's child care needs.

243.1 **EFFECTIVE DATE.** This section is effective April 23, 2018.

243.2 Sec. 16. Minnesota Statutes 2016, section 119B.10, subdivision 1, is amended to read:

243.3 Subdivision 1. **Assistance for persons seeking and retaining employment.** (a) Persons
243.4 who are seeking employment and who are eligible for assistance under this section are
243.5 eligible to receive up to 240 hours of child care assistance per calendar year.

243.6 (b) At application and redetermination, employed persons who work at least an average
243.7 of 20 hours and full-time students who work at least an average of ten hours a week and
243.8 receive at least a minimum wage for all hours worked are eligible for ~~continued~~ child care
243.9 assistance for employment. For purposes of this section, work-study programs must be
243.10 counted as employment. An employed person with an MFIP or DWP employment plan
243.11 shall receive child care assistance as specified in the person's employment plan. Child care
243.12 assistance during employment must be authorized as provided in paragraphs (c) and (d).

243.13 (c) When the person works for an hourly wage and the hourly wage is equal to or greater
243.14 than the applicable minimum wage, child care assistance shall be provided for the ~~actual~~
243.15 hours of employment, break, and mealtime during the employment and travel time up to
243.16 two hours per day.

243.17 (d) When the person does not work for an hourly wage, child care assistance must be
243.18 provided for the lesser of:

243.19 (1) the amount of child care determined by dividing gross earned income by the applicable
243.20 minimum wage, up to one hour every eight hours for meals and break time, plus up to two
243.21 hours per day for travel time; or

243.22 (2) the amount of child care equal to the actual amount of child care used during
243.23 employment, including break and mealtime during employment, and travel time up to two
243.24 hours per day.

243.25 **EFFECTIVE DATE.** This section is effective December 18, 2017.

243.26 Sec. 17. Minnesota Statutes 2016, section 119B.10, is amended by adding a subdivision
243.27 to read:

243.28 **Subd. 3. Assistance for persons attending an approved education or training**
243.29 **program.** (a) Money for an eligible person according to sections 119B.03, subdivision 3,
243.30 and 119B.05, subdivision 1, shall be used to reduce child care costs for a student. The county
243.31 shall not limit the duration of child care subsidies for a person in an employment or

244.1 educational program unless the person is ineligible for child care funds. Any other limitation
244.2 must be based on county policies included in the approved child care fund plan.

244.3 (b) To be eligible, the student must be in good standing and be making satisfactory
244.4 progress toward the degree. The maximum length of time a student is eligible for child care
244.5 assistance under the child care fund for education and training is no more than the time
244.6 necessary to complete the credit requirements for an associate's or baccalaureate degree as
244.7 determined by the educational institution. Time limitations for child care assistance do not
244.8 apply to basic or remedial educational programs needed for postsecondary education or
244.9 employment. Basic or remedial educational programs include high school, general
244.10 equivalency diploma, and English as a second language programs. A program exempt from
244.11 this time limit must not run concurrently with a postsecondary program.

244.12 (c) If a student meets the conditions of paragraphs (a) and (b), child care assistance must
244.13 be authorized for all hours of class time and credit hours, including independent study and
244.14 internships, and up to two hours of travel time per day. A postsecondary student shall receive
244.15 four hours of child care assistance per credit hour for study time and academic appointments
244.16 per service period.

244.17 (d) For an MFIP or DWP participant, child care assistance must be authorized according
244.18 to the person's approved employment plan. If an MFIP or DWP participant receiving MFIP
244.19 or DWP child care assistance under this chapter moves to another county, continues to
244.20 participate in an authorized educational or training program, and remains eligible for MFIP
244.21 or DWP child care assistance, the participant must receive continued child care assistance
244.22 from the county responsible for the person's current employment plan under section 256G.07.

244.23 (e) If a person with an approved education program under section 119B.03, subdivision
244.24 3, or 119B.05, subdivision 1, begins receiving MFIP or DWP assistance, the person continues
244.25 to receive child care assistance for the approved education program until the person's
244.26 education is included in an approved MFIP or DWP employment plan or until
244.27 redetermination, whichever occurs first.

244.28 (f) If a person's MFIP or DWP assistance ends and the approved MFIP or DWP
244.29 employment plan included education, the person continues to be eligible for child care
244.30 assistance for education under transition year child care assistance until the person's education
244.31 is included in an approved education plan or until redetermination.

244.32 **EFFECTIVE DATE.** This section is effective December 18, 2017.

245.1 Sec. 18. **[119B.105] EXTENDED ELIGIBILITY AND AUTHORIZATION.**

245.2 **Subdivision 1. Three-month extended eligibility period.** (a) A family in a situation
245.3 under paragraph (b) continues to be eligible for up to three months or until the family's
245.4 redetermination, whichever occurs first, rather than losing eligibility or having the family's
245.5 eligibility suspended. During extended eligibility, the amount of child care authorized shall
245.6 continue at the same number or more hours. The family must continue to meet all other
245.7 eligibility requirements under this chapter.

245.8 (b) The family's three-month extended eligibility period applies when:

245.9 (1) a participant's employment or education program ends permanently;

245.10 (2) the other parent moves in and does not participate in an authorized activity;

245.11 (3) a participant's MFIP assistance ends and the participant is not participating in an
245.12 authorized activity or the participant's participation in an authorized activity is unknown;

245.13 (4) a student parent under section 119B.011, subdivision 19b, stops attending school;

245.14 or

245.15 (5) a participant receiving basic sliding fee child care assistance or transition year child
245.16 care assistance applied for MFIP assistance and is not participating in an authorized activity
245.17 or the participant's participation in an authorized activity is unknown.

245.18 **Subd. 2. Extended eligibility and redetermination.** (a) If the family received three
245.19 months of extended eligibility and redetermination is not due, to continue receiving child
245.20 care assistance the participant must be employed or have an education plan that meets the
245.21 requirements of section 119B.10, subdivision 3, or have an MFIP or DWP employment
245.22 plan. If child care assistance continues, the amount of child care authorized shall continue
245.23 at the same number or more hours until redetermination, unless a condition in section
245.24 119B.095, subdivision 2, paragraph (c), applies. A family subject to section 119B.095,
245.25 subdivision 1, paragraph (b), shall have child care authorized based on a verified activity
245.26 schedule.

245.27 (b) If the family's redetermination occurs before the end of the three-month extended
245.28 eligibility period to continue receiving child care assistance, the participant must verify that
245.29 the participant meets eligibility and activity requirements for child care assistance under
245.30 this chapter. If child care assistance continues, the amount of child care authorized is based
245.31 on section 119B.10. A family subject to section 119B.095, subdivision 1, paragraph (b),
245.32 shall have child care authorized based on a verified activity schedule.

245.33 **EFFECTIVE DATE.** This section is effective December 18, 2017.

246.1 Sec. 19. Minnesota Statutes 2016, section 119B.12, subdivision 2, is amended to read:

246.2 Subd. 2. **Parent fee.** A family must be assessed a parent fee for each service period. A
246.3 family's parent fee must be a fixed percentage of its annual gross income. Parent fees must
246.4 apply to families eligible for child care assistance under sections 119B.03 and 119B.05.
246.5 Income must be as defined in section 119B.011, subdivision 15. The fixed ~~percent~~ percentage
246.6 is based on the relationship of the family's annual gross income to 100 percent of the annual
246.7 state median income. Parent fees must begin at 75 percent of the poverty level. The minimum
246.8 parent fees for families between 75 percent and 100 percent of poverty level must be \$2 per
246.9 biweekly period. Parent fees must provide for graduated movement to full payment. At
246.10 initial application, the parent fee is established for the family's 12-month eligibility period.
246.11 At redetermination, if the family remains eligible, the parent fee is recalculated and is
246.12 established for the next 12-month eligibility period. A parent fee shall not increase during
246.13 the 12-month eligibility period. Payment of part or all of a family's parent fee directly to
246.14 the family's child care provider on behalf of the family by a source other than the family
246.15 shall not affect the family's eligibility for child care assistance, and the amount paid shall
246.16 be excluded from the family's income. Child care providers who accept third-party payments
246.17 must maintain family specific documentation of payment source, amount, and time period
246.18 covered by the payment.

246.19 **EFFECTIVE DATE.** This section is effective October 23, 2017.

246.20 Sec. 20. Minnesota Statutes 2016, section 119B.13, subdivision 1, is amended to read:

246.21 Subdivision 1. **Subsidy restrictions.** (a) Beginning February 3, 2014, the maximum
246.22 rate paid for child care assistance in any county or county price cluster under the child care
246.23 fund shall be the greater of the 25th percentile of the 2011 child care provider rate survey
246.24 or the maximum rate effective November 28, 2011. For a child care provider located within
246.25 the boundaries of a city located in two or more of the counties of Benton, Sherburne, and
246.26 Stearns, the maximum rate paid for child care assistance shall be equal to the maximum
246.27 rate paid in the county with the highest maximum reimbursement rates or the provider's
246.28 charge, whichever is less. The commissioner may: (1) assign a county with no reported
246.29 provider prices to a similar price cluster; and (2) consider county level access when
246.30 determining final price clusters.

246.31 (b) A rate which includes a special needs rate paid under subdivision 3 may be in excess
246.32 of the maximum rate allowed under this subdivision.

246.33 (c) The department shall monitor the effect of this paragraph on provider rates. The
246.34 county shall pay the provider's full charges for every child in care up to the maximum

247.1 established. The commissioner shall determine the maximum rate for each type of care on
 247.2 an hourly, full-day, and weekly basis, including special needs and disability care.

247.3 (d) If a child uses one provider, the maximum payment ~~to a provider~~ for one day of care
 247.4 must not exceed the daily rate. The maximum payment ~~to a provider~~ for one week of care
 247.5 must not exceed the weekly rate.

247.6 (e) If a child uses two providers under section 119B.097, the maximum payment must
 247.7 not exceed:

247.8 (1) the daily rate for one day of care;

247.9 (2) the weekly rate for one week of care by the child's primary provider; and

247.10 (3) two daily rates during two weeks of care by a child's secondary provider.

247.11 ~~(d)~~ (f) Child care providers receiving reimbursement under this chapter must not be paid
 247.12 activity fees or an additional amount above the maximum rates for care provided during
 247.13 nonstandard hours for families receiving assistance.

247.14 ~~(e)~~ (g) If the provider charge is greater than the maximum provider rate allowed,
 247.15 the parent is responsible for payment of the difference in the rates in addition to any family
 247.16 co-payment fee.

247.17 ~~(f)~~ (h) All maximum provider rates changes shall be implemented on the Monday
 247.18 following the effective date of the maximum provider rate.

247.19 ~~(g)~~ (i) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum
 247.20 registration fees in effect on January 1, 2013, shall remain in effect.

247.21 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2018. Paragraphs (d) to (i) are
 247.22 effective April 23, 2018.

247.23 Sec. 21. Minnesota Statutes 2016, section 119B.13, subdivision 6, is amended to read:

247.24 Subd. 6. **Provider payments.** (a) The provider shall bill for services provided within
 247.25 ten days of the end of the service period. ~~If bills are submitted within ten days of the end~~
 247.26 ~~of the service period,~~ Payments under the child care fund shall be made within ~~30~~ 21 days
 247.27 of receiving a complete bill from the provider. Counties or the state may establish policies
 247.28 that make payments on a more frequent basis.

247.29 (b) If a provider has received an authorization of care and been issued a billing form for
 247.30 an eligible family, the bill must be submitted within 60 days of the last date of service on
 247.31 the bill. A bill submitted more than 60 days after the last date of service must be paid if the

248.1 county determines that the provider has shown good cause why the bill was not submitted
248.2 within 60 days. Good cause must be defined in the county's child care fund plan under
248.3 section 119B.08, subdivision 3, and the definition of good cause must include county error.
248.4 Any bill submitted more than a year after the last date of service on the bill must not be
248.5 paid.

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

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

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

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

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

248.21 (4) the provider is operating after:

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

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

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

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

248.28 (6) the provider gives false child care price information.

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

249.1 (f) A county's payment policies must be included in the county's child care plan under
249.2 section 119B.08, subdivision 3. If payments are made by the state, in addition to being in
249.3 compliance with this subdivision, the payments must be made in compliance with section
249.4 16A.124.

249.5 **EFFECTIVE DATE.** This section is effective September 25, 2017.

249.6 Sec. 22. Minnesota Statutes 2016, section 245.814, is amended by adding a subdivision
249.7 to read:

249.8 **Subd. 5. Foster care parent liability insurance.** The commissioner may use federal
249.9 reimbursement money earned on an expenditure for foster care parent liability insurance
249.10 premiums to offset the costs of the premiums.

249.11 Sec. 23. Minnesota Statutes 2016, section 245A.50, subdivision 5, is amended to read:

249.12 **Subd. 5. Sudden unexpected infant death and abusive head trauma training.** (a)
249.13 License holders must document that before staff persons, caregivers, and helpers assist in
249.14 the care of infants, they are instructed on the standards in section 245A.1435 and receive
249.15 training on reducing the risk of sudden unexpected infant death. In addition, license holders
249.16 must document that before staff persons, caregivers, and helpers assist in the care of infants
249.17 and children under school age, they receive training on reducing the risk of abusive head
249.18 trauma from shaking infants and young children. The training in this subdivision may be
249.19 provided as initial training under subdivision 1 or ongoing annual training under subdivision
249.20 7.

249.21 (b) Sudden unexpected infant death reduction training required under this subdivision
249.22 must, at a minimum, address the risk factors related to sudden unexpected infant death,
249.23 means of reducing the risk of sudden unexpected infant death in child care, and license
249.24 holder communication with parents regarding reducing the risk of sudden unexpected infant
249.25 death.

249.26 (c) Abusive head trauma training required under this subdivision must, at a minimum,
249.27 address the risk factors related to shaking infants and young children, means of reducing
249.28 the risk of abusive head trauma in child care, and license holder communication with parents
249.29 regarding reducing the risk of abusive head trauma.

249.30 (d) Training for family and group family child care providers must be developed by the
249.31 commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved
249.32 by the Minnesota Center for Professional Development. Sudden unexpected infant death

250.1 reduction training and abusive head trauma training may be provided in a single course of
250.2 no more than two hours in length.

250.3 (e) Sudden unexpected infant death reduction training and abusive head trauma training
250.4 required under this subdivision must be completed in person or as allowed under subdivision
250.5 10, clause (1) or (2), at least once every two years. On the years when the license holder is
250.6 not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the
250.7 license holder must receive sudden unexpected infant death reduction training and abusive
250.8 head trauma training through a video of no more than one hour in length. The video must
250.9 be developed or approved by the commissioner.

250.10 (f) An individual who is related to the license holder as defined in section 245A.02,
250.11 subdivision 13, and who is involved only in the care of the license holder's own infant or
250.12 child under school age and who is not designated to be a caregiver, helper, or substitute, as
250.13 defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the
250.14 sudden unexpected infant death and abusive head trauma training.

250.15 Sec. 24. Minnesota Statutes 2016, section 252.27, subdivision 2a, is amended to read:

250.16 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
250.17 including a child determined eligible for medical assistance without consideration of parental
250.18 income, must contribute to the cost of services used by making monthly payments on a
250.19 sliding scale based on income, unless the child is married or has been married, parental
250.20 rights have been terminated, or the child's adoption is subsidized according to chapter 259A
250.21 or through title IV-E of the Social Security Act. The parental contribution is a partial or full
250.22 payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating,
250.23 rehabilitation, maintenance, and personal care services as defined in United States Code,
250.24 title 26, section 213, needed by the child with a chronic illness or disability.

250.25 (b) For households with adjusted gross income equal to or greater than 275 percent of
250.26 federal poverty guidelines, the parental contribution shall be computed by applying the
250.27 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

250.28 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
250.29 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
250.30 contribution shall be determined using a sliding fee scale established by the commissioner
250.31 of human services which begins at ~~2.23~~ 1.94 percent of adjusted gross income at 275 percent
250.32 of federal poverty guidelines and increases to ~~6.08~~ 5.29 percent of adjusted gross income
250.33 for those with adjusted gross income up to 545 percent of federal poverty guidelines;

251.1 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
251.2 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
251.3 ~~6.08~~ 5.29 percent of adjusted gross income;

251.4 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
251.5 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
251.6 shall be determined using a sliding fee scale established by the commissioner of human
251.7 services which begins at ~~6.08~~ 5.29 percent of adjusted gross income at 675 percent of federal
251.8 poverty guidelines and increases to ~~8.1~~ 7.05 percent of adjusted gross income for those with
251.9 adjusted gross income up to 975 percent of federal poverty guidelines; and

251.10 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
251.11 guidelines, the parental contribution shall be ~~10.13~~ 8.81 percent of adjusted gross income.

251.12 If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400
251.13 prior to calculating the parental contribution. If the child resides in an institution specified
251.14 in section 256B.35, the parent is responsible for the personal needs allowance specified
251.15 under that section in addition to the parental contribution determined under this section.
251.16 The parental contribution is reduced by any amount required to be paid directly to the child
251.17 pursuant to a court order, but only if actually paid.

251.18 (c) The household size to be used in determining the amount of contribution under
251.19 paragraph (b) includes natural and adoptive parents and their dependents, including the
251.20 child receiving services. Adjustments in the contribution amount due to annual changes in
251.21 the federal poverty guidelines shall be implemented on the first day of July following
251.22 publication of the changes.

251.23 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
251.24 natural or adoptive parents determined according to the previous year's federal tax form,
251.25 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
251.26 have been used to purchase a home shall not be counted as income.

251.27 (e) The contribution shall be explained in writing to the parents at the time eligibility
251.28 for services is being determined. The contribution shall be made on a monthly basis effective
251.29 with the first month in which the child receives services. Annually upon redetermination
251.30 or at termination of eligibility, if the contribution exceeded the cost of services provided,
251.31 the local agency or the state shall reimburse that excess amount to the parents, either by
251.32 direct reimbursement if the parent is no longer required to pay a contribution, or by a
251.33 reduction in or waiver of parental fees until the excess amount is exhausted. All
251.34 reimbursements must include a notice that the amount reimbursed may be taxable income

252.1 if the parent paid for the parent's fees through an employer's health care flexible spending
252.2 account under the Internal Revenue Code, section 125, and that the parent is responsible
252.3 for paying the taxes owed on the amount reimbursed.

252.4 (f) The monthly contribution amount must be reviewed at least every 12 months; when
252.5 there is a change in household size; and when there is a loss of or gain in income from one
252.6 month to another in excess of ten percent. The local agency shall mail a written notice 30
252.7 days in advance of the effective date of a change in the contribution amount. A decrease in
252.8 the contribution amount is effective in the month that the parent verifies a reduction in
252.9 income or change in household size.

252.10 (g) Parents of a minor child who do not live with each other shall each pay the
252.11 contribution required under paragraph (a). An amount equal to the annual court-ordered
252.12 child support payment actually paid on behalf of the child receiving services shall be deducted
252.13 from the adjusted gross income of the parent making the payment prior to calculating the
252.14 parental contribution under paragraph (b).

252.15 (h) The contribution under paragraph (b) shall be increased by an additional five percent
252.16 if the local agency determines that insurance coverage is available but not obtained for the
252.17 child. For purposes of this section, "available" means the insurance is a benefit of employment
252.18 for a family member at an annual cost of no more than five percent of the family's annual
252.19 income. For purposes of this section, "insurance" means health and accident insurance
252.20 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
252.21 self-insured plan, or preferred provider organization.

252.22 Parents who have more than one child receiving services shall not be required to pay
252.23 more than the amount for the child with the highest expenditures. There shall be no resource
252.24 contribution from the parents. The parent shall not be required to pay a contribution in
252.25 excess of the cost of the services provided to the child, not counting payments made to
252.26 school districts for education-related services. Notice of an increase in fee payment must
252.27 be given at least 30 days before the increased fee is due.

252.28 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in
252.29 the 12 months prior to July 1:

252.30 (1) the parent applied for insurance for the child;

252.31 (2) the insurer denied insurance;

253.1 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
253.2 complaint or appeal, in writing, to the commissioner of health or the commissioner of
253.3 commerce, or litigated the complaint or appeal; and

253.4 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

253.5 For purposes of this section, "insurance" has the meaning given in paragraph (h).

253.6 A parent who has requested a reduction in the contribution amount under this paragraph
253.7 shall submit proof in the form and manner prescribed by the commissioner or county agency,
253.8 including, but not limited to, the insurer's denial of insurance, the written letter or complaint
253.9 of the parents, court documents, and the written response of the insurer approving insurance.
253.10 The determinations of the commissioner or county agency under this paragraph are not rules
253.11 subject to chapter 14.

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

253.13 Sec. 25. Minnesota Statutes 2016, section 256E.30, subdivision 2, is amended to read:

253.14 Subd. 2. **Allocation of money.** (a) State money appropriated and community service
253.15 block grant money allotted to the state and all money transferred to the community service
253.16 block grant from other block grants shall be allocated annually to community action agencies
253.17 and Indian reservation governments under clauses (b) and (c), and to migrant and seasonal
253.18 farmworker organizations under clause (d).

253.19 (b) The available annual money will provide base funding to all community action
253.20 agencies and the Indian reservations. Base funding amounts per agency are as follows: for
253.21 agencies with low income populations up to ~~3,999~~ 1,999, \$25,000; ~~4,000~~ 2,000 to 23,999,
253.22 \$50,000; and 24,000 or more, \$100,000.

253.23 (c) All remaining money of the annual money available after the base funding has been
253.24 determined must be allocated to each agency and reservation in proportion to the size of
253.25 the poverty level population in the agency's service area compared to the size of the poverty
253.26 level population in the state.

253.27 (d) Allocation of money to migrant and seasonal farmworker organizations must not
253.28 exceed three percent of the total annual money available. Base funding allocations must be
253.29 made for all community action agencies and Indian reservations that received money under
253.30 this subdivision, in fiscal year 1984, and for community action agencies designated under
253.31 this section with a service area population of 35,000 or greater.

254.1 Sec. 26. Minnesota Statutes 2016, section 256J.45, subdivision 2, is amended to read:

254.2 Subd. 2. **General information.** The MFIP orientation must consist of a presentation
254.3 that informs caregivers of:

254.4 (1) the necessity to obtain immediate employment;

254.5 (2) the work incentives under MFIP, including the availability of the federal earned
254.6 income tax credit and the Minnesota working family tax credit;

254.7 (3) the requirement to comply with the employment plan and other requirements of the
254.8 employment and training services component of MFIP, including a description of the range
254.9 of work and training activities that are allowable under MFIP to meet the individual needs
254.10 of participants;

254.11 (4) the consequences for failing to comply with the employment plan and other program
254.12 requirements, and that the county agency may not impose a sanction when failure to comply
254.13 is due to the unavailability of child care or other circumstances where the participant has
254.14 good cause under subdivision 3;

254.15 (5) the rights, responsibilities, and obligations of participants;

254.16 (6) the types and locations of child care services available through the county agency;

254.17 (7) the availability and the benefits of the early childhood health and developmental
254.18 screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

254.19 (8) the caregiver's eligibility for transition year child care assistance under section
254.20 119B.05;

254.21 (9) the availability of all health care programs, including transitional medical assistance;

254.22 (10) the caregiver's option to choose an employment and training provider and information
254.23 about each provider, including but not limited to, services offered, program components,
254.24 job placement rates, job placement wages, and job retention rates;

254.25 (11) the caregiver's option to request approval of an education and training plan according
254.26 to section 256J.53;

254.27 (12) the work study programs available under the higher education system; ~~and~~

254.28 (13) information about the 60-month time limit exemptions under the family violence
254.29 waiver and referral information about shelters and programs for victims of family violence;

254.30 and

254.31 (14) information about the income exclusions under section 256P.06, subdivision 2.

255.1 **EFFECTIVE DATE.** This section is effective December 1, 2018.

255.2 Sec. 27. **[256N.261] SUPPORT FOR ADOPTIVE, FOSTER, AND KINSHIP**
255.3 **FAMILIES.**

255.4 Subdivision 1. **Program established.** The commissioner shall design and implement a
255.5 coordinated program to reduce the need for placement changes or out-of-home placements
255.6 of children and youth in foster care, adoptive placements, and permanent physical and legal
255.7 custody kinship placements, and to improve the functioning and stability of these families.
255.8 To the extent federal funds are available, the commissioner shall provide the following
255.9 adoption and foster care-competent services and ensure that placements are trauma-informed
255.10 and child and family-centered:

255.11 (1) a program providing information, referrals, a parent-to-parent support network, peer
255.12 support for youth, family activities, respite care, crisis services, educational support, and
255.13 mental health services for children and youth in adoption, foster care, and kinship placements
255.14 and adoptive, foster, and kinship families in Minnesota;

255.15 (2) training offered statewide in Minnesota for adoptive and kinship families, and training
255.16 for foster families, and the professionals who serve the families, on the effects of trauma,
255.17 common disabilities of adopted children and children in foster care, and kinship placements,
255.18 and challenges in adoption, foster care, and kinship placements; and

255.19 (3) periodic evaluation of these services to ensure program effectiveness in preserving
255.20 and improving the success of adoptive, foster, and kinship placements.

255.21 Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

255.22 (b) "Child and family-centered" means individualized services that respond to a child's
255.23 or youth's strengths, interests, and current developmental stage, including social, cognitive,
255.24 emotional, physical, cultural, racial, and spiritual needs, and offer support to the entire
255.25 adoptive, foster, or kinship family.

255.26 (c) "Trauma-informed" means care that acknowledges the effect trauma has on children
255.27 and the children's families; modifies services to respond to the effects of trauma; emphasizes
255.28 skill and strength-building rather than symptom management; and focuses on the physical
255.29 and psychological safety of the child and family.

256.1 Sec. 28. Minnesota Statutes 2016, section 256P.06, subdivision 2, is amended to read:

256.2 Subd. 2. **Exempted individuals.** (a) The following members of an assistance unit under
256.3 chapters 119B and 256J are exempt from having their earned income count towards the
256.4 income of an assistance unit:

256.5 (1) children under six years old;

256.6 (2) caregivers under 20 years of age enrolled at least half-time in school; and

256.7 (3) minors enrolled in school full time.

256.8 (b) The following members of an assistance unit are exempt from having their earned
256.9 and unearned income count towards the income of an assistance unit for 12 consecutive
256.10 calendar months, beginning the month following the marriage date, for benefits under chapter
256.11 256J if the household income does not exceed 275 percent of the federal poverty guideline:

256.12 (1) a new spouse to a caretaker in an existing assistance unit; and

256.13 (2) the spouse designated by a newly married couple, both of whom were already
256.14 members of an assistance unit under chapter 256J.

256.15 (c) If members identified in paragraph (b) also receive assistance under section 119B.05,
256.16 they are exempt from having their earned and unearned income count towards the income
256.17 of the assistance unit if the household income prior to the exemption does not exceed 67
256.18 percent of the state median income for recipients for 26 consecutive biweekly periods
256.19 beginning the second biweekly period after the marriage date.

256.20 **EFFECTIVE DATE.** This section is effective December 1, 2018.

256.21 Sec. 29. Minnesota Statutes 2016, section 256P.07, subdivision 3, is amended to read:

256.22 Subd. 3. **Changes that must be reported.** An assistance unit must report the changes
256.23 or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur,
256.24 at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or
256.25 within eight calendar days of a reporting period, whichever occurs first. An assistance unit
256.26 must report other changes at the time of recertification of eligibility under section 256P.04,
256.27 subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency
256.28 could have reduced or terminated assistance for one or more payment months if a delay in
256.29 reporting a change specified under clauses (1) to (12) had not occurred, the agency must
256.30 determine whether a timely notice could have been issued on the day that the change
256.31 occurred. When a timely notice could have been issued, each month's overpayment
256.32 subsequent to that notice must be considered a client error overpayment under section

257.1 119B.11, subdivision 2a, or 256P.08. Changes in circumstances that must be reported within
257.2 ten days must also be reported for the reporting period in which those changes occurred.
257.3 Within ten days, an assistance unit must report:

257.4 (1) a change in earned income of \$100 per month or greater with the exception of a
257.5 program under chapter 119B;

257.6 (2) a change in unearned income of \$50 per month or greater with the exception of a
257.7 program under chapter 119B;

257.8 (3) a change in employment status and hours with the exception of a program under
257.9 chapter 119B;

257.10 (4) a change in address or residence;

257.11 (5) a change in household composition with the exception of programs under chapter
257.12 256I;

257.13 (6) a receipt of a lump-sum payment with the exception of a program under chapter
257.14 119B;

257.15 (7) an increase in assets if over \$9,000 with the exception of programs under chapter
257.16 119B;

257.17 (8) a change in citizenship or immigration status;

257.18 (9) a change in family status with the exception of programs under chapter 256I;

257.19 (10) a change in disability status of a unit member, with the exception of programs under
257.20 chapter 119B;

257.21 (11) a new rent subsidy or a change in rent subsidy with the exception of a program
257.22 under chapter 119B; and

257.23 (12) a sale, purchase, or transfer of real property with the exception of a program under
257.24 chapter 119B.

257.25 **EFFECTIVE DATE.** This section is effective December 18, 2017.

257.26 Sec. 30. Minnesota Statutes 2016, section 256P.07, subdivision 6, is amended to read:

257.27 Subd. 6. **Child care assistance programs-specific reporting.** (a) In addition to
257.28 subdivision 3, an assistance unit under chapter 119B, within ten days of the change, must
257.29 report:

258.1 (1) a change in a parentally responsible individual's ~~visitation schedule or custody~~
 258.2 ~~arrangement~~ schedule for any child receiving child care assistance program benefits; ~~and~~

258.3 (2) a ~~change in~~ permanent end in a parentally responsible individual's authorized activity
 258.4 ~~status~~; and

258.5 (3) if the unit's family's annual included income exceeds 85 percent of the state median
 258.6 income, adjusted for family size.

258.7 (b) An assistance unit subject to section 119B.095, subdivision 1, paragraph (b), must
 258.8 report a change in the unit's authorized activity status.

258.9 (c) An assistance unit must notify the county when the unit wants to reduce the number
 258.10 of authorized hours for children in the unit.

258.11 **EFFECTIVE DATE.** This section is effective December 18, 2017.

258.12 Sec. 31. Minnesota Statutes 2016, section 260C.451, subdivision 6, is amended to read:

258.13 Subd. 6. **Reentering foster care and accessing services after 18 years of age and up**
 258.14 **to 21 years of age.** (a) Upon request of an individual who had been under the guardianship
 258.15 of the commissioner and who has left foster care without being adopted, the responsible
 258.16 social services agency which had been the commissioner's agent for purposes of the
 258.17 guardianship shall develop with the individual a plan to increase the individual's ability to
 258.18 live safely and independently using the plan requirements of section 260C.212, subdivision
 258.19 1, paragraph (c), clause (12), and to assist the individual to meet one or more of the eligibility
 258.20 criteria in subdivision 4 if the individual wants to reenter foster care. The responsible social
 258.21 services agency shall provide foster care as required to implement the plan. The responsible
 258.22 social services agency shall enter into a voluntary placement agreement under section
 258.23 260C.229 with the individual if the plan includes foster care.

258.24 (b) Individuals who had not been under the guardianship of the commissioner of human
 258.25 services prior to 18 years of age may ask to reenter foster care after age 18 and, ~~to the extent~~
 258.26 ~~funds are available~~, the responsible social services agency that had responsibility for planning
 258.27 for the individual before discharge from foster care ~~may~~ shall provide foster care or other
 258.28 services to the individual for the purpose of increasing the individual's ability to live safely
 258.29 and independently and to meet the eligibility criteria in subdivision 3a, if the individual:

258.30 (1) was in foster care for the six consecutive months prior to the person's 18th birthday,
 258.31 or left foster care within six months prior to the person's 18th birthday, and was not
 258.32 discharged home, adopted, or received into a relative's home under a transfer of permanent
 258.33 legal and physical custody under section 260C.515, subdivision 4; or

259.1 (2) was discharged from foster care while on runaway status after age 15.

259.2 (c) In conjunction with a qualifying and eligible individual under paragraph (b) and
259.3 other appropriate persons, the responsible social services agency shall develop a specific
259.4 plan related to that individual's vocational, educational, social, or maturational needs and;
259.5 ~~to the extent funds are available~~, provide foster care as required to implement the plan. The
259.6 responsible social services agency shall enter into a voluntary placement agreement with
259.7 the individual if the plan includes foster care.

259.8 (d) A child who left foster care while under guardianship of the commissioner of human
259.9 services retains eligibility for foster care for placement at any time prior to 21 years of age.

259.10 Sec. 32. **MINNESOTA BIRTH TO AGE EIGHT PILOT PROJECT.**

259.11 **Subdivision 1. Authorization.** The commissioner of human services shall award a grant
259.12 to Dakota County to develop and implement pilots that will evaluate the impact of a
259.13 coordinated systems and service delivery approach on key developmental milestones and
259.14 outcomes that ultimately lead to reading proficiency by age eight within the target population.
259.15 The pilot program is from July 1, 2017, to June 30, 2021.

259.16 **Subd. 2. Pilot design and goals.** The pilot will establish five key developmental milestone
259.17 markers from birth to age eight. Enrollees in the pilot will be developmentally assessed and
259.18 tracked by a technology solution that tracks developmental milestones along the established
259.19 developmental continuum. If a child's progress falls below established milestones and the
259.20 weighted scoring, the coordinated service system will focus on identified areas of concern,
259.21 mobilize appropriate supportive services, and offer services to identified children and their
259.22 families.

259.23 **Subd. 3. Program participants in phase 1 target population.** Pilot program participants
259.24 must:

259.25 (1) be enrolled in a Women's Infant & Children (WIC) program;

259.26 (2) be participating in a family home visiting program, or nurse family practice, or
259.27 Healthy Families America (HFA);

259.28 (3) be children and families qualifying for and participating in early language learners
259.29 (ELL) in the school district in which they reside; and

259.30 (4) opt in and provide parental consent to participate in the pilot project.

259.31 **Subd. 4. Evaluation and report.** The county or counties shall work with a third-party
259.32 evaluator to evaluate the effectiveness of the pilot and report to the legislative committees

260.1 with jurisdiction over human services policy and finance each year by February 1 with an
260.2 update on the progress of the pilot. The final report on the pilot is due January 1, 2022.

260.3 Sec. 33. **MINNESOTA PATHWAYS TO PROSPERITY AND WELL-BEING PILOT**
260.4 **PROJECT.**

260.5 Subdivision 1. **Authorization.** The commissioner of human services may develop a
260.6 pilot project that shall test an alternative financing model for the distribution of publicly
260.7 funded benefits. The commissioner may work with interested counties to develop the pilot
260.8 and determine the waivers that are necessary to implement the pilot project based on the
260.9 pilot design in subdivisions 2 and 3, and outcome measures in subdivision 4.

260.10 Subd. 2. **Pilot project goals.** The goals of the pilot project are to:

260.11 (1) reduce the historical separation among the state programs and systems affecting
260.12 families who are receiving public assistance;

260.13 (2) eliminate, where possible, funding restrictions to allow a more comprehensive
260.14 approach to the needs of the families in the pilot project; and

260.15 (3) focus on upstream, prevention-oriented supports and interventions.

260.16 Subd. 3. **Project participants.** The pilot project developed by the commissioner may
260.17 include requirements that participants:

260.18 (1) be 26 years of age or younger with a minimum of one child;

260.19 (2) voluntarily agree to participate in the pilot project;

260.20 (3) be eligible for, applying for, or receiving public benefits including but not limited
260.21 to housing assistance, education supports, employment supports, child care, transportation
260.22 supports, medical assistance, earned income tax credit, or the child care tax credit; and

260.23 (4) be enrolled in an education program that is focused on obtaining a career that will
260.24 likely result in a livable wage.

260.25 Subd. 4. **Outcomes.** The outcome measures for the pilot project must include:

260.26 (1) improvement in the affordability, safety, and permanence of suitable housing;

260.27 (2) improvement in family functioning and stability, including in the areas of behavioral
260.28 health, incarceration, involvement with the child welfare system, or equivalent indicators;

260.29 (3) improvement in education readiness and outcomes for parents and children from
260.30 early childhood through high school, including reduction in absenteeism, preschool readiness
260.31 scores, third grade reading competency, graduation, GPA, and standardized test improvement;

261.1 (4) improvement in attachment to the workforce of one or both parents, including
 261.2 enhanced job stability; wage gains; career advancement; progress in career preparation; or
 261.3 an equivalent combination of these or related measures; and

261.4 (5) improvement in health care access and health outcomes for parents and children.

261.5 Sec. 34. **CHILD CARE CORRECTION ORDER POSTING GUIDELINES.**

261.6 No later than November 1, 2017, the commissioner shall develop guidelines for posting
 261.7 public licensing data for licensed child care programs. In developing the guidelines, the
 261.8 commissioner shall consult with stakeholders, including licensed child care center providers,
 261.9 family child care providers, and county agencies.

261.10 Sec. 35. **REPEALER.**

261.11 (a) Minnesota Statutes 2016, section 13.468, is repealed.

261.12 (b) Minnesota Statutes 2016, section 119B.07, is repealed effective December 18, 2017.

261.13 **ARTICLE 8**

261.14 **CHEMICAL AND MENTAL HEALTH SERVICES**

261.15 Section 1. Minnesota Statutes 2016, section 245.462, subdivision 9, is amended to read:

261.16 Subd. 9. **Diagnostic assessment.** (a) "Diagnostic assessment" means a written summary
 261.17 of the history, diagnosis, strengths, vulnerabilities, and general service needs of an adult
 261.18 with a mental illness using diagnostic, interview, and other relevant mental health techniques
 261.19 provided by a mental health professional used in developing an individual treatment plan
 261.20 or individual community support plan. has the meaning given in Minnesota Rules, part
 261.21 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372,
 261.22 subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or
 261.23 brief diagnostic assessment, or an adult update.

261.24 (b) A brief diagnostic assessment must include a face-to-face interview with the client
 261.25 and a written evaluation of the client by a mental health professional or a clinical trainee,
 261.26 as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or
 261.27 clinical trainee must gather initial components of a standard diagnostic assessment, including
 261.28 the client's:

261.29 (1) age;

261.30 (2) description of symptoms, including reason for referral;

262.1 (3) history of mental health treatment;

262.2 (4) cultural influences and their impact on the client; and

262.3 (5) mental status examination.

262.4 (c) On the basis of the initial components, the professional or clinical trainee must draw
262.5 a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's
262.6 immediate needs or presenting problem.

262.7 (d) Treatment sessions conducted under authorization of a brief assessment may be used
262.8 to gather additional information necessary to complete a standard diagnostic assessment or
262.9 an extended diagnostic assessment.

262.10 (e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),
262.11 unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible
262.12 for psychological testing as part of the diagnostic process.

262.13 (f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),
262.14 unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction
262.15 with the diagnostic assessment process, a client is eligible for up to three individual or family
262.16 psychotherapy sessions or family psychoeducation sessions or a combination of the above
262.17 sessions not to exceed three sessions.

262.18 (g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3),
262.19 unit (a), a brief diagnostic assessment may be used for a client's family who requires a
262.20 language interpreter to participate in the assessment.

262.21 **Sec. 2. [245.4662] GRANT PROGRAM; MENTAL HEALTH INNOVATION.**

262.22 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
262.23 the meanings given them.

262.24 (b) "Community partnership" means a project involving the collaboration of two or more
262.25 eligible applicants.

262.26 (c) "Eligible applicant" means an eligible county, Indian tribe, mental health service
262.27 provider, hospital, or community partnership. Eligible applicant does not include a
262.28 state-operated direct care and treatment facility or program under chapter 246.

262.29 (d) "Intensive residential treatment services" has the meaning given in section 256B.0622,
262.30 subdivision 2.

263.1 (e) "Metropolitan area" means the seven-county metropolitan area, as defined in section
263.2 473.121, subdivision 2.

263.3 Subd. 2. **Grants authorized.** The commissioner of human services shall, in consultation
263.4 with stakeholders, award grants to eligible applicants to plan, establish, or operate programs
263.5 to improve accessibility and quality of community-based, outpatient mental health services
263.6 and reduce the number of clients admitted to regional treatment centers and community
263.7 behavioral health hospitals. The commissioner shall award half of all grant funds to eligible
263.8 applicants in the metropolitan area and half of all grant funds to eligible applicants outside
263.9 the metropolitan area. An applicant may apply for and the commissioner may award grants
263.10 for two-year periods. The commissioner may reallocate underspending among grantees
263.11 within the same grant period. The mental health innovation account is established under
263.12 section 246.18 for ongoing funding.

263.13 Subd. 3. **Allocation of grants.** (a) An application must be on a form and contain
263.14 information as specified by the commissioner but at a minimum must contain:

263.15 (1) a description of the purpose or project for which grant funds will be used;

263.16 (2) a description of the specific problem the grant funds will address;

263.17 (3) a letter of support from the local mental health authority;

263.18 (4) a description of achievable objectives, a work plan, and a timeline for implementation
263.19 and completion of processes or projects enabled by the grant; and

263.20 (5) a process for documenting and evaluating results of the grant.

263.21 (b) The commissioner shall review each application to determine whether the application
263.22 is complete and whether the applicant and the project are eligible for a grant. In evaluating
263.23 applications according to paragraph (c), the commissioner shall establish criteria including,
263.24 but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in
263.25 describing the problem grant funds are intended to address; a description of the applicant's
263.26 proposed project; a description of the population demographics and service area of the
263.27 proposed project; the manner in which the applicant will demonstrate the effectiveness of
263.28 any projects undertaken; the proposed project's longevity and demonstrated financial
263.29 sustainability after the initial grant period; and evidence of efficiencies and effectiveness
263.30 gained through collaborative efforts. The commissioner may also consider other relevant
263.31 factors. In evaluating applications, the commissioner may request additional information
263.32 regarding a proposed project, including information on project cost. An applicant's failure

264.1 to provide the information requested disqualifies an applicant. The commissioner shall
264.2 determine the number of grants awarded.

264.3 (c) Eligible applicants may receive grants under this section for purposes including, but
264.4 not limited to, the following:

264.5 (1) intensive residential treatment services providing time-limited mental health services
264.6 in a residential setting;

264.7 (2) the creation of stand-alone urgent care centers for mental health and psychiatric
264.8 consultation services, crisis residential services, or collaboration between crisis teams and
264.9 critical access hospitals;

264.10 (3) establishing new community mental health services or expanding the capacity of
264.11 existing services, including supportive housing; and

264.12 (4) other innovative projects that improve options for mental health services in community
264.13 settings and reduce the number of clients who remain in regional treatment centers and
264.14 community behavioral health hospitals beyond when discharge is determined to be clinically
264.15 appropriate.

264.16 Subd. 4. **Report to legislature.** By December 1, 2019, the commissioner of human
264.17 services shall deliver a report to the chairs and ranking minority members of the legislative
264.18 committees with jurisdiction over mental health issues on the outcomes of the projects
264.19 funded under this section. The report shall, at a minimum, include the amount of funding
264.20 awarded for each project, a description of the programs and services funded, plans for the
264.21 long-term sustainability of the projects, and data on outcomes for the programs and services
264.22 funded. Grantees must provide information and data requested by the commissioner to
264.23 support the development of this report.

264.24 Sec. 3. Minnesota Statutes 2016, section 245.467, subdivision 2, is amended to read:

264.25 **Subd. 2. Diagnostic assessment.** All providers of residential, acute care hospital inpatient,
264.26 and regional treatment centers must complete a diagnostic assessment for each of their
264.27 clients within five days of admission. Providers of ~~outpatient and~~ day treatment services
264.28 must complete a diagnostic assessment within five days after the adult's second visit or
264.29 within 30 days after intake, whichever occurs first. In cases where a diagnostic assessment
264.30 is available and has been completed within three years preceding admission, only an adult
264.31 diagnostic assessment update is necessary. An "adult diagnostic assessment update" means
264.32 a written summary by a mental health professional of the adult's current mental health status
264.33 and service needs and includes a face-to-face interview with the adult. If the adult's mental

265.1 health status has changed markedly since the adult's most recent diagnostic assessment, a
265.2 new diagnostic assessment is required. Compliance with the provisions of this subdivision
265.3 does not ensure eligibility for medical assistance reimbursement under chapter 256B.

265.4 Sec. 4. Minnesota Statutes 2016, section 245.4871, is amended by adding a subdivision
265.5 to read:

265.6 Subd. 11a. **Diagnostic assessment.** (a) "Diagnostic assessment" has the meaning given
265.7 in Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota
265.8 Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a
265.9 standard, extended, or brief diagnostic assessment, or an adult update.

265.10 (b) A brief diagnostic assessment must include a face-to-face interview with the client
265.11 and a written evaluation of the client by a mental health professional or a clinical trainee,
265.12 as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or
265.13 clinical trainee must gather initial components of a standard diagnostic assessment, including
265.14 the client's:

265.15 (1) age;

265.16 (2) description of symptoms, including reason for referral;

265.17 (3) history of mental health treatment;

265.18 (4) cultural influences and their impact on the client; and

265.19 (5) mental status examination.

265.20 (c) On the basis of the brief components, the professional or clinical trainee must draw
265.21 a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's
265.22 immediate needs or presenting problem.

265.23 (d) Treatment sessions conducted under authorization of a brief assessment may be used
265.24 to gather additional information necessary to complete a standard diagnostic assessment or
265.25 an extended diagnostic assessment.

265.26 (e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),
265.27 unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible
265.28 for psychological testing as part of the diagnostic process.

265.29 (f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1),
265.30 unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction
265.31 with the diagnostic assessment process, a client is eligible for up to three individual or family

266.1 psychotherapy sessions or family psychoeducation sessions or a combination of the above
266.2 sessions not to exceed three sessions.

266.3 Sec. 5. Minnesota Statutes 2016, section 245.4871, is amended by adding a subdivision
266.4 to read:

266.5 Subd. 18a. **Functional assessment.** "Functional assessment" means an assessment by
266.6 the case manager of the child's:

266.7 (1) mental health symptoms as presented in the child's diagnostic assessment;

266.8 (2) mental health needs as presented in the child's diagnostic assessment;

266.9 (3) use of drugs and alcohol;

266.10 (4) vocational and educational functioning;

266.11 (5) social functioning, including the use of leisure time;

266.12 (6) interpersonal functioning, including relationships with the child's family;

266.13 (7) self-care and independent living capacity;

266.14 (8) medical and dental health;

266.15 (9) financial assistance needs;

266.16 (10) housing and transportation needs; and

266.17 (11) other needs and problems.

266.18 Sec. 6. Minnesota Statutes 2016, section 245.4876, subdivision 2, is amended to read:

266.19 Subd. 2. **Diagnostic assessment.** All residential treatment facilities and acute care
266.20 hospital inpatient treatment facilities that provide mental health services for children must
266.21 complete a diagnostic assessment for each of their child clients within five working days
266.22 of admission. Providers of ~~outpatient~~ and day treatment services for children must complete
266.23 a diagnostic assessment within five days after the child's second visit or 30 days after intake,
266.24 whichever occurs first. In cases where a diagnostic assessment is available and has been
266.25 completed within 180 days preceding admission, only updating is necessary. "Updating"
266.26 means a written summary by a mental health professional of the child's current mental health
266.27 status and service needs. If the child's mental health status has changed markedly since the
266.28 child's most recent diagnostic assessment, a new diagnostic assessment is required.
266.29 Compliance with the provisions of this subdivision does not ensure eligibility for medical
266.30 assistance reimbursement under chapter 256B.

267.1 Sec. 7. Minnesota Statutes 2016, section 245.4889, subdivision 1, is amended to read:

267.2 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
267.3 make grants from available appropriations to assist:

267.4 (1) counties;

267.5 (2) Indian tribes;

267.6 (3) children's collaboratives under section 124D.23 or 245.493; or

267.7 (4) mental health service providers.

267.8 (b) The following services are eligible for grants under this section:

267.9 (1) services to children with emotional disturbances as defined in section 245.4871,
267.10 subdivision 15, and their families;

267.11 (2) transition services under section 245.4875, subdivision 8, for young adults under
267.12 age 21 and their families;

267.13 (3) respite care services for children with severe emotional disturbances who are at risk
267.14 of out-of-home placement;

267.15 (4) children's mental health crisis services;

267.16 (5) mental health services for people from cultural and ethnic minorities;

267.17 (6) children's mental health screening and follow-up diagnostic assessment and treatment;

267.18 (7) services to promote and develop the capacity of providers to use evidence-based
267.19 practices in providing children's mental health services;

267.20 (8) school-linked mental health services, including transportation for children receiving
267.21 school-linked mental health services when school is not in session;

267.22 (9) building evidence-based mental health intervention capacity for children birth to age
267.23 five;

267.24 (10) suicide prevention and counseling services that use text messaging statewide;

267.25 (11) mental health first aid training;

267.26 (12) training for parents, collaborative partners, and mental health providers on the
267.27 impact of adverse childhood experiences and trauma and development of an interactive
267.28 Web site to share information and strategies to promote resilience and prevent trauma;

267.29 (13) transition age services to develop or expand mental health treatment and supports
267.30 for adolescents and young adults 26 years of age or younger;

268.1 (14) early childhood mental health consultation;

268.2 (15) evidence-based interventions for youth at risk of developing or experiencing a first
268.3 episode of psychosis, and a public awareness campaign on the signs and symptoms of
268.4 psychosis; ~~and~~

268.5 (16) psychiatric consultation for primary care practitioners; and

268.6 (17) providers to begin operations and meet program requirements when establishing a
268.7 new children's mental health program. These may be start-up grants.

268.8 (c) Services under paragraph (b) must be designed to help each child to function and
268.9 remain with the child's family in the community and delivered consistent with the child's
268.10 treatment plan. Transition services to eligible young adults under this paragraph ~~(b)~~ must
268.11 be designed to foster independent living in the community.

268.12 **EFFECTIVE DATE.** Clause (17) is effective the day following final enactment.

268.13 Sec. 8. Minnesota Statutes 2016, section 245.91, subdivision 4, is amended to read:

268.14 Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or
268.15 residential program as defined in section 245A.02, subdivisions 10 and 14, ~~that is required~~
268.16 ~~to be licensed by the commissioner of human services, and any agency, facility, or program~~
268.17 that provides services or treatment for mental illness, developmental disabilities, chemical
268.18 dependency, or emotional disturbance that is required to be licensed, certified, or registered
268.19 by the commissioner of human services, health, or education; and an acute care inpatient
268.20 facility that provides services or treatment for mental illness, developmental disabilities,
268.21 chemical dependency, or emotional disturbance.

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

268.23 Sec. 9. Minnesota Statutes 2016, section 245.91, subdivision 6, is amended to read:

268.24 Subd. 6. **Serious injury.** "Serious injury" means:

268.25 (1) fractures;

268.26 (2) dislocations;

268.27 (3) evidence of internal injuries;

268.28 (4) head injuries with loss of consciousness or potential for a closed head injury or
268.29 concussion without loss of consciousness requiring a medical assessment by a health care
268.30 professional, whether or not further medical attention was sought;

269.1 (5) lacerations involving injuries to tendons or organs, and those for which complications
269.2 are present;

269.3 (6) extensive second-degree or third-degree burns, and other burns for which
269.4 complications are present;

269.5 (7) extensive second-degree or third-degree frostbite, and others for which complications
269.6 are present;

269.7 (8) irreversible mobility or avulsion of teeth;

269.8 (9) injuries to the eyeball;

269.9 (10) ingestion of foreign substances and objects that are harmful;

269.10 (11) near drowning;

269.11 (12) heat exhaustion or sunstroke; ~~and~~

269.12 (13) attempted suicide; and

269.13 (14) all other injuries and incidents considered serious after an assessment by a physician
269.14 health care professional, including but not limited to self-injurious behavior, a medication
269.15 error requiring medical treatment, a suspected delay of medical treatment, a complication
269.16 of a previous injury, or a complication of medical treatment for an injury.

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

269.18 Sec. 10. Minnesota Statutes 2016, section 245.94, subdivision 1, is amended to read:

269.19 Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which
269.20 complaints to the office are to be made, reviewed, and acted upon. The ombudsman may
269.21 not levy a complaint fee.

269.22 (b) The ombudsman is a health oversight agency as defined in Code of Federal
269.23 Regulations, title 45, section 164.501. The ombudsman may access patient records according
269.24 to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph,
269.25 "records" has the meaning given in Code of Federal Regulations, title 42, section
269.26 2.53(a)(1)(i).

269.27 (c) The ombudsman may mediate or advocate on behalf of a client.

269.28 ~~(e)~~ (d) The ombudsman may investigate the quality of services provided to clients and
269.29 determine the extent to which quality assurance mechanisms within state and county
269.30 government work to promote the health, safety, and welfare of clients, ~~other than clients in~~
269.31 ~~acute care facilities who are receiving services not paid for by public funds. The ombudsman~~

270.1 ~~is a health oversight agency as defined in Code of Federal Regulations, title 45, section~~
270.2 ~~164.501.~~

270.3 ~~(d)~~ (e) At the request of a client, or upon receiving a complaint or other information
270.4 affording reasonable grounds to believe that the rights of ~~a client~~ one or more clients who
270.5 ~~is~~ may not be capable of requesting assistance have been adversely affected, the ombudsman
270.6 may gather information and data about and analyze, on behalf of the client, the actions of
270.7 an agency, facility, or program.

270.8 ~~(e)~~ (f) The ombudsman may gather, on behalf of ~~a client~~ one or more clients, records of
270.9 an agency, facility, or program, or records related to clinical drug trials from the University
270.10 of Minnesota Department of Psychiatry, if the records relate to a matter that is within the
270.11 scope of the ombudsman's authority. If the records are private and the client is capable of
270.12 providing consent, the ombudsman shall first obtain the client's consent. The ombudsman
270.13 is not required to obtain consent for access to private data on clients with developmental
270.14 disabilities and individuals served by the Minnesota sex offender program. The ombudsman
270.15 may also take photographic or videographic evidence while reviewing the actions of an
270.16 agency, facility, or program, with the consent of the client. The ombudsman is not required
270.17 to obtain consent for access to private data on decedents who were receiving services for
270.18 mental illness, developmental disabilities, chemical dependency, or emotional disturbance.
270.19 All data collected, created, received, or maintained by the ombudsman are governed by
270.20 chapter 13 and other applicable law.

270.21 ~~(f)~~ (g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person
270.22 to appear, give testimony, or produce documents or other evidence that the ombudsman
270.23 considers relevant to a matter under inquiry. The ombudsman may petition the appropriate
270.24 court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part
270.25 of an investigation possesses the same privileges that a witness possesses in the courts or
270.26 under the law of this state. Data obtained from a person under this paragraph are private
270.27 data as defined in section 13.02, subdivision 12.

270.28 ~~(g)~~ (h) The ombudsman may, at reasonable times in the course of conducting a review,
270.29 enter and view premises within the control of an agency, facility, or program.

270.30 ~~(h)~~ (i) The ombudsman may attend Department of Human Services Review Board and
270.31 Special Review Board proceedings; proceedings regarding the transfer of clients, as defined
270.32 in section 246.50, subdivision 4, between institutions operated by the Department of Human
270.33 Services; and, subject to the consent of the affected client, other proceedings affecting the
270.34 rights of clients. The ombudsman is not required to obtain consent to attend meetings or

271.1 proceedings and have access to private data on clients with developmental disabilities and
 271.2 individuals served by the Minnesota sex offender program.

271.3 ~~(j)~~ (j) The ombudsman shall gather data of agencies, facilities, or programs classified
 271.4 as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding
 271.5 services provided to clients with developmental disabilities and individuals served by the
 271.6 Minnesota sex offender program.

271.7 ~~(k)~~ (k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant
 271.8 licensing or regulatory officials before undertaking a review of an action of the facility or
 271.9 program.

271.10 (l) The Office of Ombudsman shall provide the services of the Civil Commitment
 271.11 Training and Resource Center.

271.12 ~~(m)~~ (m) The ombudsman shall monitor the treatment of individuals participating in a
 271.13 University of Minnesota Department of Psychiatry clinical drug trial and ensure that all
 271.14 protections for human subjects required by federal law and the Institutional Review Board
 271.15 are provided.

271.16 ~~(n)~~ (n) Sections 245.91 to 245.97 are in addition to other provisions of law under which
 271.17 any other remedy or right is provided.

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

271.19 Sec. 11. Minnesota Statutes 2016, section 245.97, subdivision 6, is amended to read:

271.20 Subd. 6. **Terms, compensation, and removal.** The membership terms, compensation,
 271.21 and removal of members of the committee and the filling of membership vacancies are
 271.22 governed by section ~~15.0575~~ 15.0597.

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

271.24 Sec. 12. Minnesota Statutes 2016, section 245A.03, subdivision 2, is amended to read:

271.25 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

271.26 (1) residential or nonresidential programs that are provided to a person by an individual
 271.27 who is related unless the residential program is a child foster care placement made by a
 271.28 local social services agency or a licensed child-placing agency, except as provided in
 271.29 subdivision 2a;

271.30 (2) nonresidential programs that are provided by an unrelated individual to persons from
 271.31 a single related family;

- 272.1 (3) residential or nonresidential programs that are provided to adults who do not ~~abuse~~
272.2 ~~chemicals or who do not have a chemical dependency~~ misuse substances or have a substance
272.3 use disorder, a mental illness, a developmental disability, a functional impairment, or a
272.4 physical disability;
- 272.5 (4) sheltered workshops or work activity programs that are certified by the commissioner
272.6 of employment and economic development;
- 272.7 (5) programs operated by a public school for children 33 months or older;
- 272.8 (6) nonresidential programs primarily for children that provide care or supervision for
272.9 periods of less than three hours a day while the child's parent or legal guardian is in the
272.10 same building as the nonresidential program or present within another building that is
272.11 directly contiguous to the building in which the nonresidential program is located;
- 272.12 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
272.13 under section 245A.02;
- 272.14 (8) board and lodge facilities licensed by the commissioner of health that do not provide
272.15 children's residential services under Minnesota Rules, chapter 2960, mental health or chemical
272.16 dependency treatment;
- 272.17 (9) homes providing programs for persons placed by a county or a licensed agency for
272.18 legal adoption, unless the adoption is not completed within two years;
- 272.19 (10) programs licensed by the commissioner of corrections;
- 272.20 (11) recreation programs for children or adults that are operated or approved by a park
272.21 and recreation board whose primary purpose is to provide social and recreational activities;
- 272.22 (12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA
272.23 as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in
272.24 section 315.51, whose primary purpose is to provide child care or services to school-age
272.25 children;
- 272.26 (13) Head Start nonresidential programs which operate for less than 45 days in each
272.27 calendar year;
- 272.28 (14) noncertified boarding care homes unless they provide services for five or more
272.29 persons whose primary diagnosis is mental illness or a developmental disability;
- 272.30 (15) programs for children such as scouting, boys clubs, girls clubs, and sports and art
272.31 programs, and nonresidential programs for children provided for a cumulative total of less
272.32 than 30 days in any 12-month period;

- 273.1 (16) residential programs for persons with mental illness, that are located in hospitals;
- 273.2 (17) the religious instruction of school-age children; Sabbath or Sunday schools; or the
- 273.3 congregative care of children by a church, congregation, or religious society during the period
- 273.4 used by the church, congregation, or religious society for its regular worship;
- 273.5 (18) camps licensed by the commissioner of health under Minnesota Rules, chapter
- 273.6 4630;
- 273.7 (19) mental health outpatient services for adults with mental illness or children with
- 273.8 emotional disturbance;
- 273.9 (20) residential programs serving school-age children whose sole purpose is cultural or
- 273.10 educational exchange, until the commissioner adopts appropriate rules;
- 273.11 (21) community support services programs as defined in section 245.462, subdivision
- 273.12 6, and family community support services as defined in section 245.4871, subdivision 17;
- 273.13 (22) the placement of a child by a birth parent or legal guardian in a preadoptive home
- 273.14 for purposes of adoption as authorized by section 259.47;
- 273.15 (23) settings registered under chapter 144D which provide home care services licensed
- 273.16 by the commissioner of health to fewer than seven adults;
- 273.17 (24) ~~chemical dependency or substance abuse use disorder~~ treatment activities of licensed
- 273.18 professionals in private practice as defined in ~~Minnesota Rules, part 9530.6405, subpart 15,~~
- 273.19 ~~when the treatment activities are not paid for by the consolidated chemical dependency~~
- 273.20 ~~treatment fund~~ section 245G.01, subdivision 17;
- 273.21 (25) consumer-directed community support service funded under the Medicaid waiver
- 273.22 for persons with developmental disabilities when the individual who provided the service
- 273.23 is:
- 273.24 (i) the same individual who is the direct payee of these specific waiver funds or paid by
- 273.25 a fiscal agent, fiscal intermediary, or employer of record; and
- 273.26 (ii) not otherwise under the control of a residential or nonresidential program that is
- 273.27 required to be licensed under this chapter when providing the service;
- 273.28 (26) a program serving only children who are age 33 months or older, that is operated
- 273.29 by a nonpublic school, for no more than four hours per day per child, with no more than 20
- 273.30 children at any one time, and that is accredited by:
- 273.31 (i) an accrediting agency that is formally recognized by the commissioner of education
- 273.32 as a nonpublic school accrediting organization; or

274.1 (ii) an accrediting agency that requires background studies and that receives and
 274.2 investigates complaints about the services provided.

274.3 A program that asserts its exemption from licensure under item (ii) shall, upon request
 274.4 from the commissioner, provide the commissioner with documentation from the accrediting
 274.5 agency that verifies: that the accreditation is current; that the accrediting agency investigates
 274.6 complaints about services; and that the accrediting agency's standards require background
 274.7 studies on all people providing direct contact services; ~~or~~

274.8 (27) a program operated by a nonprofit organization incorporated in Minnesota or another
 274.9 state that serves youth in kindergarten through grade 12; provides structured, supervised
 274.10 youth development activities; and has learning opportunities take place before or after
 274.11 school, on weekends, or during the summer or other seasonal breaks in the school calendar.
 274.12 A program exempt under this clause is not eligible for child care assistance under chapter
 274.13 119B. A program exempt under this clause must:

274.14 (i) have a director or supervisor on site who is responsible for overseeing written policies
 274.15 relating to the management and control of the daily activities of the program, ensuring the
 274.16 health and safety of program participants, and supervising staff and volunteers;

274.17 (ii) have obtained written consent from a parent or legal guardian for each youth
 274.18 participating in activities at the site; and

274.19 (iii) have provided written notice to a parent or legal guardian for each youth at the site
 274.20 that the program is not licensed or supervised by the state of Minnesota and is not eligible
 274.21 to receive child care assistance payments;

274.22 (28) a county that is an eligible vendor under section 254B.05 to provide care coordination
 274.23 and comprehensive assessment services; or

274.24 (29) a recovery community organization that is an eligible vendor under section 254B.05
 274.25 to provide peer recovery support services.

274.26 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
 274.27 building in which a nonresidential program is located if it shares a common wall with the
 274.28 building in which the nonresidential program is located or is attached to that building by
 274.29 skyway, tunnel, atrium, or common roof.

274.30 (c) Except for the home and community-based services identified in section 245D.03,
 274.31 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
 274.32 provided and funded according to an approved federal waiver plan where licensure is
 274.33 specifically identified as not being a condition for the services and funding.

275.1 **EFFECTIVE DATE.** This section is effective January 1, 2018.

275.2 Sec. 13. Minnesota Statutes 2016, section 245A.191, is amended to read:

275.3 **245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL**
 275.4 **DEPENDENCY CONSOLIDATED TREATMENT FUND.**

275.5 (a) When a ~~chemical dependency~~ substance use disorder treatment provider licensed
 275.6 under this chapter, and governed by the standards of chapter 245G or Minnesota Rules,
 275.7 parts 2960.0430 to 2960.0490 ~~or 9530.6405 to 9530.6505~~, agrees to meet the applicable
 275.8 requirements under section 254B.05, subdivision 5, ~~paragraphs (b), clauses (1) to (4) and~~
 275.9 ~~(6), (e), and (e)~~, to be eligible for enhanced funding from the chemical dependency
 275.10 consolidated treatment fund, the applicable requirements under section 254B.05 are also
 275.11 licensing requirements that may be monitored for compliance through licensing investigations
 275.12 and licensing inspections.

275.13 (b) Noncompliance with the requirements identified under paragraph (a) may result in:

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

275.16 (2) nonpayment of claims submitted by the license holder for public program
 275.17 reimbursement;

275.18 (3) recovery of payments made for the service;

275.19 (4) disenrollment in the public payment program; or

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

275.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

275.22 Sec. 14. **[245G.01] DEFINITIONS.**

275.23 Subdivision 1. Scope. The terms used in this chapter have the meanings given them.

275.24 Subd. 2. Administration of medication. "Administration of medication" means providing
 275.25 a medication to a client, and includes the following tasks, performed in the following order:

275.26 (1) checking the client's medication record;

275.27 (2) preparing the medication for administration;

275.28 (3) administering the medication to the client;

276.1 (4) documenting the administration of the medication, or the reason for not administering
276.2 a medication as prescribed; and

276.3 (5) reporting information to a licensed practitioner or a nurse regarding a problem with
276.4 the administration of medication or the client's refusal to take the medication, if applicable.

276.5 Subd. 3. **Adolescent.** "Adolescent" means an individual under 18 years of age.

276.6 Subd. 4. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning
276.7 given in section 148F.01, subdivision 5.

276.8 Subd. 5. **Applicant.** "Applicant" has the meaning given in section 245A.02, subdivision
276.9 3.

276.10 Subd. 6. **Capacity management system.** "Capacity management system" means a
276.11 database maintained by the department to compile and make information available to the
276.12 public about the waiting list status and current admission capability of each opioid treatment
276.13 program.

276.14 Subd. 7. **Central registry.** "Central registry" means a database maintained by the
276.15 department to collect identifying information from two or more programs about an individual
276.16 applying for maintenance treatment or detoxification treatment for opioid addiction to
276.17 prevent an individual's concurrent enrollment in more than one program.

276.18 Subd. 8. **Client.** "Client" means an individual accepted by a license holder for assessment
276.19 or treatment of a substance use disorder. An individual remains a client until the license
276.20 holder no longer provides or intends to provide the individual with treatment service.

276.21 Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services.

276.22 Subd. 10. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both
276.23 a substance use disorder and a mental health disorder.

276.24 Subd. 11. **Department.** "Department" means the Department of Human Services.

276.25 Subd. 12. **Direct contact.** "Direct contact" has the meaning given for "direct contact"
276.26 in section 245C.02, subdivision 11.

276.27 Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive and visual
276.28 communication between a client and a treatment service provider and includes services
276.29 delivered in person or via telemedicine.

276.30 Subd. 14. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

277.1 Subd. 15. **License holder.** "License holder" has the meaning given in section 245A.02,
277.2 subdivision 9.

277.3 Subd. 16. **Licensed practitioner.** "Licensed practitioner" means an individual who is
277.4 authorized to prescribe medication as defined in section 151.01, subdivision 23.

277.5 Subd. 17. **Licensed professional in private practice.** "Licensed professional in private
277.6 practice" means an individual who:

277.7 (1) is licensed under chapter 148F, or is exempt from licensure under that chapter but
277.8 is otherwise licensed to provide alcohol and drug counseling services;

277.9 (2) practices solely within the permissible scope of the individual's license as defined
277.10 in the law authorizing licensure; and

277.11 (3) does not affiliate with other licensed or unlicensed professionals to provide alcohol
277.12 and drug counseling services. Affiliation does not include conferring with another
277.13 professional or making a client referral.

277.14 Subd. 18. **Nurse.** "Nurse" means an individual licensed and currently registered to
277.15 practice professional or practical nursing as defined in section 148.171, subdivisions 14 and
277.16 15.

277.17 Subd. 19. **Opioid treatment program or OTP.** "Opioid treatment program" or "OTP"
277.18 means a program or practitioner engaged in opioid treatment of an individual that provides
277.19 dispensing of an opioid agonist treatment medication, along with a comprehensive range
277.20 of medical and rehabilitative services, when clinically necessary, to an individual to alleviate
277.21 the adverse medical, psychological, or physical effects of an opioid addiction. OTP includes
277.22 detoxification treatment, short-term detoxification treatment, long-term detoxification
277.23 treatment, maintenance treatment, comprehensive maintenance treatment, and interim
277.24 maintenance treatment.

277.25 Subd. 20. **Paraprofessional.** "Paraprofessional" means an employee, agent, or
277.26 independent contractor of the license holder who performs tasks to support treatment service.
277.27 A paraprofessional may be referred to by a variety of titles including but not limited to
277.28 technician, case aide, or counselor assistant. If currently a client of the license holder, the
277.29 client cannot be a paraprofessional for the license holder.

277.30 Subd. 21. **Student intern.** "Student intern" means an individual who is authorized by a
277.31 licensing board to provide services under supervision of a licensed professional.

277.32 Subd. 22. **Substance.** "Substance" means alcohol, solvents, controlled substances as
277.33 defined in section 152.01, subdivision 4, and other mood-altering substances.

278.1 Subd. 23. **Substance use disorder.** "Substance use disorder" has the meaning given in
278.2 the current Diagnostic and Statistical Manual of Mental Disorders.

278.3 Subd. 24. **Substance use disorder treatment.** "Substance use disorder treatment" means
278.4 treatment of a substance use disorder, including the process of assessment of a client's needs,
278.5 development of planned methods, including interventions or services to address a client's
278.6 needs, provision of services, facilitation of services provided by other service providers,
278.7 and ongoing reassessment by a qualified professional when indicated. The goal of substance
278.8 use disorder treatment is to assist or support the client's efforts to recover from a substance
278.9 use disorder.

278.10 Subd. 25. **Target population.** "Target population" means individuals with a substance
278.11 use disorder and the specified characteristics that a license holder proposes to serve.

278.12 Subd. 26. **Telemedicine.** "Telemedicine" means the delivery of a substance use disorder
278.13 treatment service while the client is at an originating site and the licensed health care provider
278.14 is at a distant site as specified in section 254B.05, subdivision 5, paragraph (f).

278.15 Subd. 27. **Treatment director.** "Treatment director" means an individual who meets
278.16 the qualifications specified in section 245G.11, subdivisions 1 and 3, and is designated by
278.17 the license holder to be responsible for all aspects of the delivery of treatment service.

278.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

278.19 Sec. 15. **[245G.02] APPLICABILITY.**

278.20 Subdivision 1. **Applicability.** Except as provided in subdivisions 2 and 3, no person,
278.21 corporation, partnership, voluntary association, controlling individual, or other organization
278.22 may provide a substance use disorder treatment service to an individual with a substance
278.23 use disorder unless licensed by the commissioner.

278.24 Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county
278.25 or recovery community organization that is providing a service for which the county or
278.26 recovery community organization is an eligible vendor under section 254B.05. This chapter
278.27 does not apply to an organization whose primary functions are information, referral,
278.28 diagnosis, case management, and assessment for the purposes of client placement, education,
278.29 support group services, or self-help programs. This chapter does not apply to the activities
278.30 of a licensed professional in private practice.

278.31 Subd. 3. **Excluded hospitals.** This chapter does not apply to substance use disorder
278.32 treatment provided by a hospital licensed under chapter 62J, or under sections 144.50 to

279.1 144.56, unless the hospital accepts funds for substance use disorder treatment from the
279.2 consolidated chemical dependency treatment fund under chapter 254B, medical assistance
279.3 under chapter 256B, or MinnesotaCare or health care cost containment under chapter 256L,
279.4 or general assistance medical care formerly codified in chapter 256D.

279.5 Subd. 4. **Applicability of Minnesota Rules, chapter 2960.** A residential adolescent
279.6 substance use disorder treatment program serving an individual younger than 16 years of
279.7 age must be licensed according to Minnesota Rules, chapter 2960.

279.8 **EFFECTIVE DATE.** This section is effective January 1, 2018.

279.9 **Sec. 16. [245G.03] LICENSING REQUIREMENTS.**

279.10 Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance
279.11 use disorder treatment must comply with the general requirements in chapters 245A and
279.12 245C, sections 626.556 and 626.557, and Minnesota Rules, chapter 9544.

279.13 (b) The commissioner may grant variances to the requirements in this chapter that do
279.14 not affect the client's health or safety if the conditions in section 245A.04, subdivision 9,
279.15 are met.

279.16 Subd. 2. **Application.** Before the commissioner issues a license, an applicant must
279.17 submit, on forms provided by the commissioner, any documents the commissioner requires.

279.18 Subd. 3. **Change in license terms.** (a) The commissioner must determine whether a
279.19 new license is needed when a change in clauses (1) to (4) occurs. A license holder must
279.20 notify the commissioner before a change in one of the following occurs:

279.21 (1) the Department of Health's licensure of the program;

279.22 (2) whether the license holder provides services specified in sections 245G.18 to 245G.22;

279.23 (3) location; or

279.24 (4) capacity if the license holder meets the requirements of section 245G.21.

279.25 (b) A license holder must notify the commissioner and must apply for a new license if
279.26 there is a change in program ownership.

279.27 **EFFECTIVE DATE.** This section is effective January 1, 2018.

279.28 **Sec. 17. [245G.04] INITIAL SERVICES PLAN.**

279.29 (a) The license holder must complete an initial services plan on the day of service
279.30 initiation. The plan must address the client's immediate health and safety concerns, identify

280.1 the needs to be addressed in the first treatment session, and make treatment suggestions for
280.2 the client during the time between intake and completion of the individual treatment plan.

280.3 (b) The initial services plan must include a determination of whether a client is a
280.4 vulnerable adult as defined in section 626.5572, subdivision 21. An adult client of a
280.5 residential program is a vulnerable adult. An individual abuse prevention plan, according
280.6 to sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph
280.7 (b), is required for a client who meets the definition of vulnerable adult.

280.8 **EFFECTIVE DATE.** This section is effective January 1, 2018.

280.9 Sec. 18. **[245G.05] COMPREHENSIVE ASSESSMENT AND ASSESSMENT**
280.10 **SUMMARY.**

280.11 Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the
280.12 client's substance use disorder must be administered face-to-face by an alcohol and drug
280.13 counselor within three calendar days after service initiation for a residential program or
280.14 during the initial session for all other programs. If the comprehensive assessment is not
280.15 completed during the initial session, the client-centered reason for the delay must be
280.16 documented in the client's file and the planned completion date. If the client received a
280.17 comprehensive assessment that authorized the treatment service, an alcohol and drug
280.18 counselor must review the assessment to determine compliance with this subdivision,
280.19 including applicable timelines. If available, the alcohol and drug counselor may use current
280.20 information provided by a referring agency or other source as a supplement. Information
280.21 gathered more than 45 days before the date of admission is not considered current. The
280.22 comprehensive assessment must include sufficient information to complete the assessment
280.23 summary according to subdivision 2 and the individual treatment plan according to section
280.24 245G.06. The comprehensive assessment must include information about the client's needs
280.25 that relate to substance use and personal strengths that support recovery, including:

280.26 (1) age, sex, cultural background, sexual orientation, living situation, economic status,
280.27 and level of education;

280.28 (2) circumstances of service initiation;

280.29 (3) previous attempts at treatment for substance misuse or substance use disorder,
280.30 compulsive gambling, or mental illness;

280.31 (4) substance use history including amounts and types of substances used, frequency
280.32 and duration of use, periods of abstinence, and circumstances of relapse, if any. For each

281.1 substance used within the previous 30 days, the information must include the date of the
281.2 most recent use and previous withdrawal symptoms;

281.3 (5) specific problem behaviors exhibited by the client when under the influence of
281.4 substances;

281.5 (6) family status, family history, including history or presence of physical or sexual
281.6 abuse, level of family support, and substance misuse or substance use disorder of a family
281.7 member or significant other;

281.8 (7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns
281.9 are being addressed by a health care professional;

281.10 (8) mental health history and psychiatric status, including symptoms, disability, current
281.11 treatment supports, and psychotropic medication needed to maintain stability; the assessment
281.12 must utilize screening tools approved by the commissioner pursuant to section 245.4863 to
281.13 identify whether the client screens positive for co-occurring disorders;

281.14 (9) arrests and legal interventions related to substance use;

281.15 (10) ability to function appropriately in work and educational settings;

281.16 (11) ability to understand written treatment materials, including rules and the client's
281.17 rights;

281.18 (12) risk-taking behavior, including behavior that puts the client at risk of exposure to
281.19 blood-borne or sexually transmitted diseases;

281.20 (13) social network in relation to expected support for recovery and leisure time activities
281.21 that are associated with substance use;

281.22 (14) whether the client is pregnant and, if so, the health of the unborn child and the
281.23 client's current involvement in prenatal care;

281.24 (15) whether the client recognizes problems related to substance use and is willing to
281.25 follow treatment recommendations; and

281.26 (16) collateral information. If the assessor gathered sufficient information from the
281.27 referral source or the client to apply the criteria in parts 9530.6620 and 9530.6622, a collateral
281.28 contact is not required.

281.29 (b) If the client is identified as having opioid use disorder or seeking treatment for opioid
281.30 use disorder, the program must provide educational information to the client concerning:

281.31 (1) risks for opioid use disorder and dependence;

282.1 (2) treatment options, including the use of a medication for opioid use disorder;

282.2 (3) the risk of and recognizing opioid overdose; and

282.3 (4) the use, availability, and administration of naloxone to respond to opioid overdose.

282.4 (c) The commissioner shall develop educational materials that are supported by research
282.5 and updated periodically. The license holder must use the educational materials that are
282.6 approved by the commissioner to comply with this requirement.

282.7 (d) If the comprehensive assessment is completed to authorize treatment service for the
282.8 client, at the earliest opportunity during the assessment interview the assessor shall determine
282.9 if:

282.10 (1) the client is in severe withdrawal and likely to be a danger to self or others;

282.11 (2) the client has severe medical problems that require immediate attention; or

282.12 (3) the client has severe emotional or behavioral symptoms that place the client or others
282.13 at risk of harm.

282.14 If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the
282.15 assessment interview and follow the procedures in the program's medical services plan
282.16 under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The
282.17 assessment interview may resume when the condition is resolved.

282.18 Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an
282.19 assessment summary within three calendar days after service initiation for a residential
282.20 program and within three sessions for all other programs. If the comprehensive assessment
282.21 is used to authorize the treatment service, the alcohol and drug counselor must prepare an
282.22 assessment summary on the same date the comprehensive assessment is completed. If the
282.23 comprehensive assessment and assessment summary are to authorize treatment services,
282.24 the assessor must determine appropriate services for the client using the dimensions in
282.25 Minnesota Rules, part 9530.6622, and document the recommendations.

282.26 (b) An assessment summary must include:

282.27 (1) a risk description according to section 245G.05 for each dimension listed in paragraph
282.28 (c);

282.29 (2) a narrative summary supporting the risk descriptions; and

282.30 (3) a determination of whether the client has a substance use disorder.

283.1 (c) An assessment summary must contain information relevant to treatment service
283.2 planning and recorded in the dimensions in clauses (1) to (6). The license holder must
283.3 consider:

283.4 (1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with
283.5 withdrawal symptoms and current state of intoxication;

283.6 (2) Dimension 2, biomedical conditions and complications; the degree to which any
283.7 physical disorder of the client would interfere with treatment for substance use, and the
283.8 client's ability to tolerate any related discomfort. The license holder must determine the
283.9 impact of continued chemical use on the unborn child, if the client is pregnant;

283.10 (3) Dimension 3, emotional, behavioral, and cognitive conditions and complications;
283.11 the degree to which any condition or complication is likely to interfere with treatment for
283.12 substance use or with functioning in significant life areas and the likelihood of harm to self
283.13 or others;

283.14 (4) Dimension 4, readiness for change; the support necessary to keep the client involved
283.15 in treatment service;

283.16 (5) Dimension 5, relapse, continued use, and continued problem potential; the degree
283.17 to which the client recognizes relapse issues and has the skills to prevent relapse of either
283.18 substance use or mental health problems; and

283.19 (6) Dimension 6, recovery environment; whether the areas of the client's life are
283.20 supportive of or antagonistic to treatment participation and recovery.

283.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

283.22 Sec. 19. **[245G.06] INDIVIDUAL TREATMENT PLAN.**

283.23 Subdivision 1. **General.** Each client must have an individual treatment plan developed
283.24 by an alcohol and drug counselor within seven days of service initiation for a residential
283.25 program and within three sessions for all other programs. The client must have active, direct
283.26 involvement in selecting the anticipated outcomes of the treatment process and developing
283.27 the treatment plan. The individual treatment plan must be signed by the client and the alcohol
283.28 and drug counselor and document the client's involvement in the development of the plan.
283.29 The plan may be a continuation of the initial services plan required in section 245G.04.
283.30 Treatment planning must include ongoing assessment of client needs. An individual treatment
283.31 plan must be updated based on new information gathered about the client's condition and
283.32 on whether methods identified have the intended effect. A change to the plan must be signed
283.33 by the client and the alcohol and drug counselor. The plan must provide for the involvement

284.1 of the client's family and people selected by the client as important to the success of treatment
284.2 at the earliest opportunity, consistent with the client's treatment needs and written consent.

284.3 Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six
284.4 dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue
284.5 identified in the assessment summary, prioritized according to the client's needs and focus,
284.6 and must include:

284.7 (1) specific methods to address each identified need, including amount, frequency, and
284.8 anticipated duration of treatment service. The methods must be appropriate to the client's
284.9 language, reading skills, cultural background, and strengths;

284.10 (2) resources to refer the client to when the client's needs are to be addressed concurrently
284.11 by another provider; and

284.12 (3) goals the client must reach to complete treatment and terminate services.

284.13 Subd. 3. **Documentation of treatment services; treatment plan review.** (a) A review
284.14 of all treatment services must be documented weekly and include a review of:

284.15 (1) care coordination activities;

284.16 (2) medical and other appointments the client attended;

284.17 (3) issues related to medications that are not documented in the medication administration
284.18 record; and

284.19 (4) issues related to attendance for treatment services, including the reason for any client
284.20 absence from a treatment service.

284.21 (b) A note must be entered immediately following any significant event. A significant
284.22 event is an event that impacts the client's relationship with other clients, staff, the client's
284.23 family, or the client's treatment plan.

284.24 (c) A treatment plan review must be entered in a client's file weekly or after each treatment
284.25 service, whichever is less frequent, by the staff member providing the service. The review
284.26 must indicate the span of time covered by the review and each of the six dimensions listed
284.27 in section 245G.05, subdivision 2, paragraph (c). The review must:

284.28 (1) indicate the date, type, and amount of each treatment service provided and the client's
284.29 response to each service;

284.30 (2) address each goal in the treatment plan and whether the methods to address the goals
284.31 are effective;

- 285.1 (3) include monitoring of any physical and mental health problems;
- 285.2 (4) document the participation of others;
- 285.3 (5) document staff recommendations for changes in the methods identified in the treatment
- 285.4 plan and whether the client agrees with the change; and
- 285.5 (6) include a review and evaluation of the individual abuse prevention plan according
- 285.6 to section 245A.65.
- 285.7 (d) Each entry in a client's record must be accurate, legible, signed, and dated. A late
- 285.8 entry must be clearly labeled "late entry." A correction to an entry must be made in a way
- 285.9 in which the original entry can still be read.
- 285.10 Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a
- 285.11 discharge summary for each client. The summary must be completed within five days of
- 285.12 the client's service termination or within five days from the client's or program's decision
- 285.13 to terminate services, whichever is earlier.
- 285.14 (b) The service discharge summary must be recorded in the six dimensions listed in
- 285.15 section 245G.05, subdivision 2, paragraph (c), and include the following information:
- 285.16 (1) the client's issues, strengths, and needs while participating in treatment, including
- 285.17 services provided;
- 285.18 (2) the client's progress toward achieving each goal identified in the individual treatment
- 285.19 plan;
- 285.20 (3) a risk description according to section 245G.05; and
- 285.21 (4) the reasons for and circumstances of service termination. If a program discharges a
- 285.22 client at staff request, the reason for discharge and the procedure followed for the decision
- 285.23 to discharge must be documented and comply with the program's policies on staff-initiated
- 285.24 client discharge. If a client is discharged at staff request, the program must give the client
- 285.25 crisis and other referrals appropriate for the client's needs and offer assistance to the client
- 285.26 to access the services.
- 285.27 (c) For a client who successfully completes treatment, the summary must also include:
- 285.28 (1) the client's living arrangements at service termination;
- 285.29 (2) continuing care recommendations, including transitions between more or less intense
- 285.30 services, or more frequent to less frequent services, and referrals made with specific attention
- 285.31 to continuity of care for mental health, as needed;

286.1 (3) service termination diagnosis; and

286.2 (4) the client's prognosis.

286.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

286.4 Sec. 20. **[245G.07] TREATMENT SERVICE.**

286.5 Subdivision 1. **Treatment service.** (a) A license holder must offer the following treatment
286.6 services, unless clinically inappropriate and the justifying clinical rationale is documented:

286.7 (1) individual and group counseling to help the client identify and address needs related
286.8 to substance use and develop strategies to avoid harmful substance use after discharge and
286.9 to help the client obtain the services necessary to establish a lifestyle free of the harmful
286.10 effects of substance use disorder;

286.11 (2) client education strategies to avoid inappropriate substance use and health problems
286.12 related to substance use and the necessary lifestyle changes to regain and maintain health.

286.13 Client education must include information on tuberculosis education on a form approved
286.14 by the commissioner, the human immunodeficiency virus according to section 245A.19,
286.15 other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis.

286.16 A licensed alcohol and drug counselor must be present during an educational group;

286.17 (3) a service to help the client integrate gains made during treatment into daily living
286.18 and to reduce the client's reliance on a staff member for support;

286.19 (4) a service to address issues related to co-occurring disorders, including client education
286.20 on symptoms of mental illness, the possibility of comorbidity, and the need for continued
286.21 medication compliance while recovering from substance use disorder. A group must address
286.22 co-occurring disorders, as needed. When treatment for mental health problems is indicated,
286.23 the treatment must be integrated into the client's individual treatment plan;

286.24 (5) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
286.25 services provided one-to-one by an individual in recovery. Peer support services include
286.26 education, advocacy, mentoring through self-disclosure of personal recovery experiences,
286.27 attending recovery and other support groups with a client, accompanying the client to
286.28 appointments that support recovery, assistance accessing resources to obtain housing,
286.29 employment, education, and advocacy services, and nonclinical recovery support to assist
286.30 the transition from treatment into the recovery community; and

287.1 (6) on July 1, 2018, or upon federal approval, whichever is later, care coordination
287.2 provided by an individual who meets the staff qualifications in section 245G.11, subdivision
287.3 7. Care coordination services include:

287.4 (i) assistance in coordination with significant others to help in the treatment planning
287.5 process whenever possible;

287.6 (ii) assistance in coordination with and follow up for medical services as identified in
287.7 the treatment plan;

287.8 (iii) facilitation of referrals to substance use disorder services as indicated by a client's
287.9 medical provider, comprehensive assessment, or treatment plan;

287.10 (iv) facilitation of referrals to mental health services as identified by a client's
287.11 comprehensive assessment or treatment plan;

287.12 (v) assistance with referrals to economic assistance, social services, housing resources,
287.13 and prenatal care according to the client's needs;

287.14 (vi) life skills advocacy and support accessing treatment follow-up, disease management,
287.15 and education services, including referral and linkages to long-term services and supports
287.16 as needed; and

287.17 (vii) documentation of the provision of care coordination services in the client's file.

287.18 (b) A treatment service provided to a client must be provided according to the individual
287.19 treatment plan and must consider cultural differences and special needs of a client.

287.20 Subd. 2. **Additional treatment service.** A license holder may provide or arrange the
287.21 following additional treatment service as a part of the client's individual treatment plan:

287.22 (1) relationship counseling provided by a qualified professional to help the client identify
287.23 the impact of the client's substance use disorder on others and to help the client and persons
287.24 in the client's support structure identify and change behaviors that contribute to the client's
287.25 substance use disorder;

287.26 (2) therapeutic recreation to allow the client to participate in recreational activities
287.27 without the use of mood-altering chemicals and to plan and select leisure activities that do
287.28 not involve the inappropriate use of chemicals;

287.29 (3) stress management and physical well-being to help the client reach and maintain an
287.30 appropriate level of health, physical fitness, and well-being;

287.31 (4) living skills development to help the client learn basic skills necessary for independent
287.32 living;

288.1 (5) employment or educational services to help the client become financially independent;
288.2 (6) socialization skills development to help the client live and interact with others in a
288.3 positive and productive manner; and

288.4 (7) room, board, and supervision at the treatment site to provide the client with a safe
288.5 and appropriate environment to gain and practice new skills.

288.6 Subd. 3. **Counselors.** A treatment service, including therapeutic recreation, must be
288.7 provided by an alcohol and drug counselor according to section 245G.11, unless the
288.8 individual providing the service is specifically qualified according to the accepted credential
288.9 required to provide the service. Therapeutic recreation does not include planned leisure
288.10 activities.

288.11 Subd. 4. **Location of service provision.** The license holder may provide services at any
288.12 of the license holder's licensed locations or at another suitable location including a school,
288.13 government building, medical or behavioral health facility, or social service organization,
288.14 upon notification and approval of the commissioner. If services are provided off site from
288.15 the licensed site, the reason for the provision of services remotely must be documented.

288.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

288.17 Sec. 21. **[245G.08] MEDICAL SERVICES.**

288.18 Subdivision 1. **Health care services.** An applicant or license holder must maintain a
288.19 complete description of the health care services, nursing services, dietary services, and
288.20 emergency physician services offered by the applicant or license holder.

288.21 Subd. 2. **Procedures.** The applicant or license holder must have written procedures for
288.22 obtaining a medical intervention for a client, that are approved in writing by a physician
288.23 who is licensed under chapter 147, unless:

288.24 (1) the license holder does not provide a service under section 245G.21; and

288.25 (2) a medical intervention is referred to 911, the emergency telephone number, or the
288.26 client's physician.

288.27 Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone
288.28 available for emergency treatment of opioid overdose must have a written standing order
288.29 protocol by a physician who is licensed under chapter 147, that permits the license holder
288.30 to maintain a supply of naloxone on site, and must require staff to undergo specific training
288.31 in administration of naloxone.

289.1 Subd. 4. **Consultation services.** The license holder must have access to and document
289.2 the availability of a licensed mental health professional to provide diagnostic assessment
289.3 and treatment planning assistance.

289.4 Subd. 5. **Administration of medication and assistance with self-medication.** (a) A
289.5 license holder must meet the requirements in this subdivision if a service provided includes
289.6 the administration of medication.

289.7 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
289.8 licensed practitioner or a registered nurse the task of administration of medication or assisting
289.9 with self-medication, must:

289.10 (1) successfully complete a medication administration training program for unlicensed
289.11 personnel through an accredited Minnesota postsecondary educational institution. A staff
289.12 member's completion of the course must be documented in writing and placed in the staff
289.13 member's personnel file;

289.14 (2) be trained according to a formalized training program that is taught by a registered
289.15 nurse and offered by the license holder. The training must include the process for
289.16 administration of naloxone, if naloxone is kept on site. A staff member's completion of the
289.17 training must be documented in writing and placed in the staff member's personnel records;
289.18 or

289.19 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
289.20 registered nurse must be employed or contracted to develop the policies and procedures for
289.21 administration of medication or assisting with self-administration of medication, or both.

289.22 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
289.23 23. The registered nurse's supervision must include, at a minimum, monthly on-site
289.24 supervision or more often if warranted by a client's health needs. The policies and procedures
289.25 must include:

289.26 (1) a provision that a delegation of administration of medication is limited to the
289.27 administration of a medication that is administered orally, topically, or as a suppository, an
289.28 eye drop, an ear drop, or an inhalant;

289.29 (2) a provision that each client's file must include documentation indicating whether
289.30 staff must conduct the administration of medication or the client must self-administer
289.31 medication, or both;

289.32 (3) a provision that a client may carry emergency medication such as nitroglycerin as
289.33 instructed by the client's physician;

290.1 (4) a provision for the client to self-administer medication when a client is scheduled to
290.2 be away from the facility;

290.3 (5) a provision that if a client self-administers medication when the client is present in
290.4 the facility, the client must self-administer medication under the observation of a trained
290.5 staff member;

290.6 (6) a provision that when a license holder serves a client who is a parent with a child,
290.7 the parent may only administer medication to the child under a staff member's supervision;

290.8 (7) requirements for recording the client's use of medication, including staff signatures
290.9 with date and time;

290.10 (8) guidelines for when to inform a nurse of problems with self-administration of
290.11 medication, including a client's failure to administer, refusal of a medication, adverse
290.12 reaction, or error; and

290.13 (9) procedures for acceptance, documentation, and implementation of a prescription,
290.14 whether written, verbal, telephonic, or electronic.

290.15 Subd. 6. **Control of drugs.** A license holder must have and implement written policies
290.16 and procedures developed by a registered nurse that contain:

290.17 (1) a requirement that each drug must be stored in a locked compartment. A Schedule
290.18 II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked
290.19 compartment, permanently affixed to the physical plant or medication cart;

290.20 (2) a system which accounts for all scheduled drugs each shift;

290.21 (3) a procedure for recording the client's use of medication, including the signature of
290.22 the staff member who completed the administration of the medication with the time and
290.23 date;

290.24 (4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

290.25 (5) a statement that only authorized personnel are permitted access to the keys to a locked
290.26 compartment;

290.27 (6) a statement that no legend drug supply for one client shall be given to another client;
290.28 and

290.29 (7) a procedure for monitoring the available supply of naloxone on site, replenishing
290.30 the naloxone supply when needed, and destroying naloxone according to clause (4).

290.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

291.1 Sec. 22. **[245G.09] CLIENT RECORDS.**

291.2 **Subdivision 1. Client records required.** (a) A license holder must maintain a file of
291.3 current and accurate client records on the premises where the treatment service is provided
291.4 or coordinated. For services provided off site, client records must be available at the program
291.5 and adhere to the same clinical and administrative policies and procedures as services
291.6 provided on site. The content and format of client records must be uniform and entries in
291.7 each record must be signed and dated by the staff member making the entry. Client records
291.8 must be protected against loss, tampering, or unauthorized disclosure according to section
291.9 254A.09, chapter 13, and Code of Federal Regulations, title 42, chapter 1, part 2, subpart
291.10 B, sections 2.1 to 2.67, and title 45, parts 160 to 164.

291.11 (b) The program must have a policy and procedure that identifies how the program will
291.12 track and record client attendance at treatment activities, including the date, duration, and
291.13 nature of each treatment service provided to the client.

291.14 **Subd. 2. Record retention.** The client records of a discharged client must be retained
291.15 by a license holder for seven years. A license holder that ceases to provide treatment service
291.16 must retain client records for seven years from the date of facility closure and must notify
291.17 the commissioner of the location of the client records and the name of the individual
291.18 responsible for maintaining the client's records.

291.19 **Subd. 3. Contents.** Client records must contain the following:

291.20 (1) documentation that the client was given information on client rights and
291.21 responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided
291.22 an orientation to the program abuse prevention plan required under section 245A.65,
291.23 subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record
291.24 must contain documentation that the client was provided educational information according
291.25 to section 245G.05, subdivision 1, paragraph (b);

291.26 (2) an initial services plan completed according to section 245G.04;

291.27 (3) a comprehensive assessment completed according to section 245G.05;

291.28 (4) an assessment summary completed according to section 245G.05, subdivision 2;

291.29 (5) an individual abuse prevention plan according to sections 245A.65, subdivision 2,
291.30 and 626.557, subdivision 14, when applicable;

291.31 (6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

292.1 (7) documentation of treatment services and treatment plan review according to section
292.2 245G.06, subdivision 3; and

292.3 (8) a summary at the time of service termination according to section 245G.06,
292.4 subdivision 4.

292.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

292.6 Sec. 23. **[245G.10] STAFF REQUIREMENTS.**

292.7 Subdivision 1. **Treatment director.** A license holder must have a treatment director.

292.8 Subd. 2. **Alcohol and drug counselor supervisor.** A license holder must employ an
292.9 alcohol and drug counselor supervisor who meets the requirements of section 245G.11,
292.10 subdivision 4. An individual may be simultaneously employed as a treatment director,
292.11 alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual
292.12 meets the qualifications for each position. If an alcohol and drug counselor is simultaneously
292.13 employed as an alcohol and drug counselor supervisor or treatment director, that individual
292.14 must be considered a 0.5 full-time equivalent alcohol and drug counselor for staff
292.15 requirements under subdivision 4.

292.16 Subd. 3. **Responsible staff member.** A treatment director must designate a staff member
292.17 who, when present in the facility, is responsible for the delivery of treatment service. A
292.18 license holder must have a designated staff member during all hours of operation. A license
292.19 holder providing room and board and treatment at the same site must have a responsible
292.20 staff member on duty 24 hours a day. The designated staff member must know and understand
292.21 the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

292.22 Subd. 4. **Staff requirement.** It is the responsibility of the license holder to determine
292.23 an acceptable group size based on each client's needs except that treatment services provided
292.24 in a group shall not exceed 16 clients. A counselor in an opioid treatment program must not
292.25 supervise more than 50 clients. The license holder must maintain a record that documents
292.26 compliance with this subdivision.

292.27 Subd. 5. **Medical emergency.** When a client is present, a license holder must have at
292.28 least one staff member on the premises who has a current American Red Cross standard
292.29 first aid certificate or an equivalent certificate and at least one staff member on the premises
292.30 who has a current American Red Cross community, American Heart Association, or
292.31 equivalent CPR certificate. A single staff member with both certifications satisfies this
292.32 requirement.

293.1 **EFFECTIVE DATE.** This section is effective January 1, 2018.

293.2 Sec. 24. **[245G.11] STAFF QUALIFICATIONS.**

293.3 Subdivision 1. **General qualifications.** (a) All staff members who have direct contact
293.4 must be 18 years of age or older. At the time of employment, each staff member must meet
293.5 the qualifications in this subdivision. For purposes of this subdivision, "problematic substance
293.6 use" means a behavior or incident listed by the license holder in the personnel policies and
293.7 procedures according to section 245G.13, subdivision 1, clause (5).

293.8 (b) A treatment director, supervisor, nurse, counselor, student intern, or other professional
293.9 must be free of problematic substance use for at least the two years immediately preceding
293.10 employment and must sign a statement attesting to that fact.

293.11 (c) A paraprofessional, recovery peer, or any other staff member with direct contact
293.12 must be free of problematic substance use for at least one year immediately preceding
293.13 employment and must sign a statement attesting to that fact.

293.14 Subd. 2. **Employment; prohibition on problematic substance use.** A staff member
293.15 with direct contact must be free from problematic substance use as a condition of
293.16 employment, but is not required to sign additional statements. A staff member with direct
293.17 contact who is not free from problematic substance use must be removed from any
293.18 responsibilities that include direct contact for the time period specified in subdivision 1.
293.19 The time period begins to run on the date of the last incident of problematic substance use
293.20 as described in the facility's policies and procedures according to section 245G.13,
293.21 subdivision 1, clause (5).

293.22 Subd. 3. **Treatment directors.** A treatment director must:

293.23 (1) have at least one year of work experience in direct service to an individual with
293.24 substance use disorder or one year of work experience in the management or administration
293.25 of direct service to an individual with substance use disorder;

293.26 (2) have a baccalaureate degree or three years of work experience in administration or
293.27 personnel supervision in human services; and

293.28 (3) know and understand the implications of this chapter, chapter 245A, and sections
293.29 626.556, 626.557, and 626.5572. Demonstration of the treatment director's knowledge must
293.30 be documented in the personnel record.

293.31 Subd. 4. **Alcohol and drug counselor supervisors.** An alcohol and drug counselor
293.32 supervisor must:

294.1 (1) meet the qualification requirements in subdivision 5;

294.2 (2) have three or more years of experience providing individual and group counseling
294.3 to individuals with substance use disorder; and

294.4 (3) know and understand the implications of this chapter and sections 245A.65, 626.556,
294.5 626.557, and 626.5572.

294.6 Subd. 5. **Alcohol and drug counselor qualifications.** (a) An alcohol and drug counselor
294.7 must either be licensed or exempt from licensure under chapter 148F.

294.8 (b) An individual who is exempt from licensure under chapter 148F, must meet one of
294.9 the following additional requirements:

294.10 (1) completion of at least a baccalaureate degree with a major or concentration in social
294.11 work, nursing, sociology, human services, or psychology, or licensure as a registered nurse;
294.12 successful completion of a minimum of 120 hours of classroom instruction in which each
294.13 of the core functions listed in chapter 148F is covered; and successful completion of 440
294.14 hours of supervised experience as an alcohol and drug counselor, either as a student or a
294.15 staff member;

294.16 (2) completion of at least 270 hours of drug counselor training in which each of the core
294.17 functions listed in chapter 148F is covered, and successful completion of 880 hours of
294.18 supervised experience as an alcohol and drug counselor, either as a student or as a staff
294.19 member;

294.20 (3) current certification as an alcohol and drug counselor or alcohol and drug counselor
294.21 reciprocal, through the evaluation process established by the International Certification and
294.22 Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.;

294.23 (4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling
294.24 education from an accredited school or educational program and 880 hours of alcohol and
294.25 drug counseling practicum; or

294.26 (5) employment in a program formerly licensed under Minnesota Rules, parts 9530.5000
294.27 to 9530.6400, and successful completion of 6,000 hours of supervised work experience in
294.28 a licensed program as an alcohol and drug counselor prior to January 1, 2005.

294.29 (c) An alcohol and drug counselor may not provide a treatment service that requires
294.30 professional licensure unless the individual possesses the necessary license. For the purposes
294.31 of enforcing this section, the commissioner has the authority to monitor a service provider's
294.32 compliance with the relevant standards of the service provider's profession and may issue

295.1 licensing actions against the license holder according to sections 245A.05, 245A.06, and
295.2 245A.07, based on the commissioner's determination of noncompliance.

295.3 Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights,
295.4 according to section 148F.165, and staff member responsibilities. A paraprofessional may
295.5 not admit, transfer, or discharge a client but may be responsible for the delivery of treatment
295.6 service according to section 245G.10, subdivision 3.

295.7 Subd. 7. **Care coordination provider qualifications.** (a) Care coordination must be
295.8 provided by qualified staff. An individual is qualified to provide care coordination if the
295.9 individual:

295.10 (1) is skilled in the process of identifying and assessing a wide range of client needs;

295.11 (2) is knowledgeable about local community resources and how to use those resources
295.12 for the benefit of the client;

295.13 (3) has successfully completed 30 hours of classroom instruction on care coordination
295.14 for an individual with substance use disorder;

295.15 (4) has either:

295.16 (i) a bachelor's degree in one of the behavioral sciences or related fields; or

295.17 (ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest
295.18 Indian Council on Addictive Disorders; and

295.19 (5) has at least 2,000 hours of supervised experience working with individuals with
295.20 substance use disorder.

295.21 (b) A care coordinator must receive at least one hour of supervision regarding individual
295.22 service delivery from an alcohol and drug counselor weekly.

295.23 Subd. 8. **Recovery peer qualifications.** A recovery peer must:

295.24 (1) have a high school diploma or its equivalent;

295.25 (2) have a minimum of one year in recovery from substance use disorder;

295.26 (3) hold a current credential from a certification body approved by the commissioner
295.27 that demonstrates skills and training in the domains of ethics and boundaries, advocacy,
295.28 mentoring and education, and recovery and wellness support; and

295.29 (4) receive ongoing supervision in areas specific to the domains of the recovery peer's
295.30 role by an alcohol and drug counselor or an individual with a certification approved by the
295.31 commissioner.

296.1 Subd. 9. **Volunteers.** A volunteer may provide treatment service when the volunteer is
296.2 supervised and can be seen or heard by a staff member meeting the criteria in subdivision
296.3 4 or 5, but may not practice alcohol and drug counseling unless qualified under subdivision
296.4 5.

296.5 Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible
296.6 for a treatment service performed by a student intern and must review and sign each
296.7 assessment, progress note, and individual treatment plan prepared by a student intern. A
296.8 student intern must receive the orientation and training required in section 245G.13,
296.9 subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be
296.10 students or licensing candidates with time documented to be directly related to the provision
296.11 of treatment services for which the staff are authorized.

296.12 Subd. 11. **Individuals with temporary permit.** An individual with a temporary permit
296.13 from the Board of Behavioral Health and Therapy may provide chemical dependency
296.14 treatment service according to this subdivision if they meet the requirements of either
296.15 paragraph (a) or (b).

296.16 (a) An individual with a temporary permit must be supervised by a licensed alcohol and
296.17 drug counselor assigned by the license holder. The supervising licensed alcohol and drug
296.18 counselor must document the amount and type of supervision provided at least on a weekly
296.19 basis. The supervision must relate to the clinical practice.

296.20 (b) An individual with a temporary permit must be supervised by a clinical supervisor
296.21 approved by the Board of Behavioral Health and Therapy. The supervision must be
296.22 documented and meet the requirements of section 148F.04, subdivision 4.

296.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

296.24 Sec. 25. **[245G.12] PROVIDER POLICIES AND PROCEDURES.**

296.25 A license holder must develop a written policies and procedures manual, indexed
296.26 according to section 245A.04, subdivision 14, paragraph (c), that provides staff members
296.27 immediate access to all policies and procedures and provides a client and other authorized
296.28 parties access to all policies and procedures. The manual must contain the following
296.29 materials:

296.30 (1) assessment and treatment planning policies, including screening for mental health
296.31 concerns and treatment objectives related to the client's identified mental health concerns
296.32 in the client's treatment plan;

296.33 (2) policies and procedures regarding HIV according to section 245A.19;

297.1 (3) the license holder's methods and resources to provide information on tuberculosis
297.2 and tuberculosis screening to each client and to report a known tuberculosis infection
297.3 according to section 144.4804;

297.4 (4) personnel policies according to section 245G.13;

297.5 (5) policies and procedures that protect a client's rights according to section 245G.15;

297.6 (6) a medical services plan according to section 245G.08;

297.7 (7) emergency procedures according to section 245G.16;

297.8 (8) policies and procedures for maintaining client records according to section 245G.09;

297.9 (9) procedures for reporting the maltreatment of minors according to section 626.556,

297.10 and vulnerable adults according to sections 245A.65, 626.557, and 626.5572;

297.11 (10) a description of treatment services, including the amount and type of services

297.12 provided;

297.13 (11) the methods used to achieve desired client outcomes;

297.14 (12) the hours of operation; and

297.15 (13) the target population served.

297.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

297.17 **Sec. 26. [245G.13] PROVIDER PERSONNEL POLICIES.**

297.18 **Subdivision 1. Personnel policy requirements.** A license holder must have written

297.19 personnel policies that are available to each staff member. The personnel policies must:

297.20 (1) ensure that staff member retention, promotion, job assignment, or pay are not affected

297.21 by a good faith communication between a staff member and the department, the Department

297.22 of Health, the ombudsman for mental health and developmental disabilities, law enforcement,

297.23 or a local agency for the investigation of a complaint regarding a client's rights, health, or

297.24 safety;

297.25 (2) contain a job description for each staff member position specifying responsibilities,

297.26 degree of authority to execute job responsibilities, and qualification requirements;

297.27 (3) provide for a job performance evaluation based on standards of job performance

297.28 conducted on a regular and continuing basis, including a written annual review;

297.29 (4) describe behavior that constitutes grounds for disciplinary action, suspension, or

297.30 dismissal, including policies that address staff member problematic substance use and the

298.1 requirements of section 245G.11, subdivision 1, policies prohibiting personal involvement
298.2 with a client in violation of chapter 604, and policies prohibiting client abuse described in
298.3 sections 245A.65, 626.556, 626.557, and 626.5572;

298.4 (5) identify how the program will identify whether behaviors or incidents are problematic
298.5 substance use, including a description of how the facility must address:

298.6 (i) receiving treatment for substance use within the period specified for the position in
298.7 the staff qualification requirements, including medication-assisted treatment;

298.8 (ii) substance use that negatively impacts the staff member's job performance;

298.9 (iii) chemical use that affects the credibility of treatment services with a client, referral
298.10 source, or other member of the community;

298.11 (iv) symptoms of intoxication or withdrawal on the job; and

298.12 (v) the circumstances under which an individual who participates in monitoring by the
298.13 health professional services program for a substance use or mental health disorder is able
298.14 to provide services to the program's clients;

298.15 (6) include a chart or description of the organizational structure indicating lines of
298.16 authority and responsibilities;

298.17 (7) include orientation within 24 working hours of starting for each new staff member
298.18 based on a written plan that, at a minimum, must provide training related to the staff member's
298.19 specific job responsibilities, policies and procedures, client confidentiality, HIV minimum
298.20 standards, and client needs; and

298.21 (8) include policies outlining the license holder's response to a staff member with a
298.22 behavior problem that interferes with the provision of treatment service.

298.23 Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member
298.24 has the training described in this subdivision.

298.25 (b) Each staff member must be trained every two years in:

298.26 (1) client confidentiality rules and regulations and client ethical boundaries; and

298.27 (2) emergency procedures and client rights as specified in sections 144.651, 148F.165,
298.28 and 253B.03.

298.29 (c) Annually each staff member with direct contact must be trained on mandatory
298.30 reporting as specified in sections 245A.65, 626.556, 626.5561, 626.557, and 626.5572,

299.1 including specific training covering the license holder's policies for obtaining a release of
299.2 client information.

299.3 (d) Upon employment and annually thereafter, each staff member with direct contact
299.4 must receive training on HIV minimum standards according to section 245A.19.

299.5 (e) A treatment director, supervisor, nurse, or counselor must have a minimum of 12
299.6 hours of training in co-occurring disorders that includes competencies related to philosophy,
299.7 trauma-informed care, screening, assessment, diagnosis and person-centered treatment
299.8 planning, documentation, programming, medication, collaboration, mental health
299.9 consultation, and discharge planning. A new staff member who has not obtained the training
299.10 must complete the training within six months of employment. A staff member may request,
299.11 and the license holder may grant, credit for relevant training obtained before employment,
299.12 which must be documented in the staff member's personnel file.

299.13 Subd. 3. **Personnel files.** The license holder must maintain a separate personnel file for
299.14 each staff member. At a minimum, the personnel file must conform to the requirements of
299.15 this chapter. A personnel file must contain the following:

299.16 (1) a completed application for employment signed by the staff member and containing
299.17 the staff member's qualifications for employment;

299.18 (2) documentation related to the staff member's background study data, according to
299.19 chapter 245C;

299.20 (3) for a staff member who provides psychotherapy services, employer names and
299.21 addresses for the past five years for which the staff member provided psychotherapy services,
299.22 and documentation of an inquiry required by sections 604.20 to 604.205 made to the staff
299.23 member's former employer regarding substantiated sexual contact with a client;

299.24 (4) documentation that the staff member completed orientation and training;

299.25 (5) documentation that the staff member meets the requirements in section 245G.11;

299.26 (6) documentation demonstrating the staff member's compliance with section 245G.08,
299.27 subdivision 3, for a staff member who conducts administration of medication; and

299.28 (7) documentation demonstrating the staff member's compliance with section 245G.18,
299.29 subdivision 2, for a staff member that treats an adolescent client.

299.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

300.1 **Sec. 27. [245G.14] SERVICE INITIATION AND TERMINATION POLICIES.**

300.2 Subdivision 1. **Service initiation policy.** A license holder must have a written service
300.3 initiation policy containing service initiation preferences that comply with this section and
300.4 Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria.
300.5 The license holder must not initiate services for an individual who does not meet the service
300.6 initiation criteria. The service initiation criteria must be either posted in the area of the
300.7 facility where services for a client are initiated, or given to each interested person upon
300.8 request. Titles of each staff member authorized to initiate services for a client must be listed
300.9 in the services initiation and termination policies.

300.10 Subd. 2. **License holder responsibilities.** (a) The license holder must have and comply
300.11 with a written protocol for (1) assisting a client in need of care not provided by the license
300.12 holder, and (2) a client who poses a substantial likelihood of harm to the client or others, if
300.13 the behavior is beyond the behavior management capabilities of the staff members.

300.14 (b) A service termination and denial of service initiation that poses an immediate threat
300.15 to the health of any individual or requires immediate medical intervention must be referred
300.16 to a medical facility capable of admitting the client.

300.17 (c) A service termination policy and a denial of service initiation that involves the
300.18 commission of a crime against a license holder's staff member or on a license holder's
300.19 premises, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and
300.20 title 45, parts 160 to 164, must be reported to a law enforcement agency with jurisdiction.

300.21 Subd. 3. **Service termination policies.** A license holder must have a written policy
300.22 specifying the conditions when a client must be terminated from service. The service
300.23 termination policy must include:

300.24 (1) procedures for a client whose services were terminated under subdivision 2;

300.25 (2) a description of client behavior that constitutes reason for a staff-requested service
300.26 termination and a process for providing this information to a client;

300.27 (3) a requirement that before discharging a client from a residential setting, for not
300.28 reaching treatment plan goals, the license holder must confer with other interested persons
300.29 to review the issues involved in the decision. The documentation requirements for a
300.30 staff-requested service termination must describe why the decision to discharge is warranted,
300.31 the reasons for the discharge, and the alternatives considered or attempted before discharging
300.32 the client;

301.1 (4) procedures consistent with section 253B.16, subdivision 2, that staff members must
301.2 follow when a client admitted under chapter 253B is to have services terminated;

301.3 (5) procedures a staff member must follow when a client leaves against staff or medical
301.4 advice and when the client may be dangerous to the client or others, including a policy that
301.5 requires a staff member to assist the client with assessing needs of care or other resources;

301.6 (6) procedures for communicating staff-approved service termination criteria to a client,
301.7 including the expectations in the client's individual treatment plan according to section
301.8 245G.06; and

301.9 (7) titles of each staff member authorized to terminate a client's service must be listed
301.10 in the service initiation and service termination policies.

301.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

301.12 **Sec. 28. [245G.15] CLIENT RIGHTS PROTECTION.**

301.13 Subdivision 1. **Explanation.** A client has the rights identified in sections 144.651,
301.14 148F.165, 253B.03, and 254B.02, subdivision 2, as applicable. The license holder must
301.15 give each client at service initiation a written statement of the client's rights and
301.16 responsibilities. A staff member must review the statement with a client at that time.

301.17 Subd. 2. **Grievance procedure.** At service initiation, the license holder must explain
301.18 the grievance procedure to the client or the client's representative. The grievance procedure
301.19 must be posted in a place visible to clients, and made available upon a client's or former
301.20 client's request. The grievance procedure must require that:

301.21 (1) a staff member helps the client develop and process a grievance;

301.22 (2) current telephone numbers and addresses of the Department of Human Services,
301.23 Licensing Division; the Office of Ombudsman for Mental Health and Developmental
301.24 Disabilities; the Department of Health Office of Health Facilities Complaints; and the Board
301.25 of Behavioral Health and Therapy, when applicable, be made available to a client; and

301.26 (3) a license holder responds to the client's grievance within three days of a staff member's
301.27 receipt of the grievance, and the client may bring the grievance to the highest level of
301.28 authority in the program if not resolved by another staff member.

301.29 Subd. 3. **Photographs of client.** (a) A photograph, video, or motion picture of a client
301.30 taken in the provision of treatment service is considered client records. A photograph for
301.31 identification and a recording by video or audio technology to enhance either therapy or
301.32 staff member supervision may be required of a client, but may only be available for use as

302.1 communications within a program. A client must be informed when the client's actions are
302.2 being recorded by camera or other technology, and the client must have the right to refuse
302.3 any recording or photography, except as authorized by this subdivision.

302.4 (b) A license holder must have a written policy regarding the use of any personal
302.5 electronic device that can record, transmit, or make images of another client. A license
302.6 holder must inform each client of this policy and the client's right to refuse being
302.7 photographed or recorded.

302.8 **EFFECTIVE DATE.** This section is effective January 1, 2018.

302.9 Sec. 29. **[245G.16] BEHAVIORAL EMERGENCY PROCEDURES.**

302.10 (a) A license holder or applicant must have written behavioral emergency procedures
302.11 that staff must follow when responding to a client who exhibits behavior that is threatening
302.12 to the safety of the client or others. Programs must incorporate person-centered planning
302.13 and trauma-informed care in the program's behavioral emergency procedure policies. The
302.14 procedures must include:

302.15 (1) a plan designed to prevent a client from hurting themselves or others;

302.16 (2) contact information for emergency resources that staff must consult when a client's
302.17 behavior cannot be controlled by the behavioral emergency procedures;

302.18 (3) types of procedures that may be used;

302.19 (4) circumstances under which behavioral emergency procedures may be used; and

302.20 (5) staff members authorized to implement behavioral emergency procedures.

302.21 (b) Behavioral emergency procedures must not be used to enforce facility rules or for
302.22 the convenience of staff. Behavioral emergency procedures must not be part of any client's
302.23 treatment plan, or used at any time for any reason except in response to specific current
302.24 behavior that threatens the safety of the client or others. Behavioral emergency procedures
302.25 may not include the use of seclusion or restraint.

302.26 **EFFECTIVE DATE.** This section is effective January 1, 2018.

302.27 Sec. 30. **[245G.17] EVALUATION.**

302.28 A license holder must participate in the drug and alcohol abuse normative evaluation
302.29 system by submitting information about each client to the commissioner in a manner
302.30 prescribed by the commissioner. A license holder must submit additional information

303.1 requested by the commissioner that is necessary to meet statutory or federal funding
303.2 requirements.

303.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

303.4 Sec. 31. **[245G.18] LICENSE HOLDERS SERVING ADOLESCENTS.**

303.5 Subdivision 1. **License.** A residential treatment program that serves an adolescent younger
303.6 than 16 years of age must be licensed as a residential program for a child in out-of-home
303.7 placement by the department unless the license holder is exempt under section 245A.03,
303.8 subdivision 2.

303.9 Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements
303.10 specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing
303.11 treatment service to an adolescent must have:

303.12 (1) an additional 30 hours of classroom instruction or one three-credit semester college
303.13 course in adolescent development. This training need only be completed one time; and

303.14 (2) at least 150 hours of supervised experience as an adolescent counselor, either as a
303.15 student or as a staff member.

303.16 Subd. 3. **Staff ratios.** At least 25 percent of a counselor's scheduled work hours must
303.17 be allocated to indirect services, including documentation of client services, coordination
303.18 of services with others, treatment team meetings, and other duties. A counseling group
303.19 consisting entirely of adolescents must not exceed 16 adolescents. It is the responsibility of
303.20 the license holder to determine an acceptable group size based on the needs of the clients.

303.21 Subd. 4. **Academic program requirements.** A client who is required to attend school
303.22 must be enrolled and attending an educational program that was approved by the Department
303.23 of Education.

303.24 Subd. 5. **Program requirements.** In addition to the requirements specified in the client's
303.25 treatment plan under section 245G.06, programs serving an adolescent must include:

303.26 (1) coordination with the school system to address the client's academic needs;

303.27 (2) when appropriate, a plan that addresses the client's leisure activities without chemical
303.28 use; and

303.29 (3) a plan that addresses family involvement in the adolescent's treatment.

303.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

304.1 Sec. 32. **[245G.19] LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.**

304.2 Subdivision 1. **Health license requirements.** In addition to the requirements of sections
304.3 245G.01 to 245G.17, a license holder that offers supervision of a child of a client is subject
304.4 to the requirements of this section. A license holder providing room and board for a client
304.5 and the client's child must have an appropriate facility license from the Department of
304.6 Health.

304.7 Subd. 2. **Supervision of a child.** "Supervision of a child" means a caregiver is within
304.8 sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can
304.9 intervene to protect the child's health and safety. For a school-age child it means a caregiver
304.10 is available to help and care for the child to protect the child's health and safety.

304.11 Subd. 3. **Policy and schedule required.** A license holder must meet the following
304.12 requirements:

304.13 (1) have a policy and schedule delineating the times and circumstances when the license
304.14 holder is responsible for supervision of a child in the program and when the child's parents
304.15 are responsible for supervision of a child. The policy must explain how the program will
304.16 communicate its policy about supervision of a child responsibility to the parent; and

304.17 (2) have written procedures addressing the actions a staff member must take if a child
304.18 is neglected or abused, including while the child is under the supervision of the child's
304.19 parent.

304.20 Subd. 4. **Additional licensing requirements.** During the times the license holder is
304.21 responsible for the supervision of a child, the license holder must meet the following
304.22 standards:

304.23 (1) child and adult ratios in Minnesota Rules, part 9502.0367;

304.24 (2) day care training in section 245A.50;

304.25 (3) behavior guidance in Minnesota Rules, part 9502.0395;

304.26 (4) activities and equipment in Minnesota Rules, part 9502.0415;

304.27 (5) physical environment in Minnesota Rules, part 9502.0425; and

304.28 (6) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license
304.29 holder has a license from the Department of Health.

304.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

305.1 Sec. 33. **[245G.20] LICENSE HOLDERS SERVING PERSONS WITH**
305.2 **CO-OCCURRING DISORDERS.**

305.3 A license holder specializing in the treatment of a person with co-occurring disorders
305.4 must:

305.5 (1) demonstrate that staff levels are appropriate for treating a client with a co-occurring
305.6 disorder, and that there are adequate staff members with mental health training;

305.7 (2) have continuing access to a medical provider with appropriate expertise in prescribing
305.8 psychotropic medication;

305.9 (3) have a mental health professional available for staff member supervision and
305.10 consultation;

305.11 (4) determine group size, structure, and content considering the special needs of a client
305.12 with a co-occurring disorder;

305.13 (5) have documentation of active interventions to stabilize mental health symptoms
305.14 present in the individual treatment plans and progress notes;

305.15 (6) have continuing documentation of collaboration with continuing care mental health
305.16 providers, and involvement of the providers in treatment planning meetings;

305.17 (7) have available program materials adapted to a client with a mental health problem;

305.18 (8) have policies that provide flexibility for a client who may lapse in treatment or may
305.19 have difficulty adhering to established treatment rules as a result of a mental illness, with
305.20 the goal of helping a client successfully complete treatment; and

305.21 (9) have individual psychotherapy and case management available during treatment
305.22 service.

305.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

305.24 Sec. 34. **[245G.21] REQUIREMENTS FOR LICENSED RESIDENTIAL**
305.25 **TREATMENT.**

305.26 Subdivision 1. **Applicability.** A license holder who provides supervised room and board
305.27 at the licensed program site as a treatment component is defined as a residential program
305.28 according to section 245A.02, subdivision 14, and is subject to this section.

305.29 Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by
305.30 the license holder. The license holder must set and post a notice of visiting rules and hours,
305.31 including both day and evening times. A client's right to receive visitors other than a personal

306.1 physician, religious adviser, county case manager, parole or probation officer, or attorney
306.2 may be subject to visiting hours established by the license holder for all clients. The treatment
306.3 director or designee may impose limitations as necessary for the welfare of a client provided
306.4 the limitation and the reasons for the limitation are documented in the client's file. A client
306.5 must be allowed to receive visits at all reasonable times from the client's personal physician,
306.6 religious adviser, county case manager, parole or probation officer, and attorney.

306.7 Subd. 3. **Client property management.** A license holder who provides room and board
306.8 and treatment services to a client in the same facility, and any license holder that accepts
306.9 client property must meet the requirements for handling client funds and property in section
306.10 245A.04, subdivision 13. License holders:

306.11 (1) may establish policies regarding the use of personal property to ensure that treatment
306.12 activities and the rights of other clients are not infringed upon;

306.13 (2) may take temporary custody of a client's property for violation of a facility policy;

306.14 (3) must retain the client's property for a minimum of seven days after the client's service
306.15 termination if the client does not reclaim property upon service termination, or for a minimum
306.16 of 30 days if the client does not reclaim property upon service termination and has received
306.17 room and board services from the license holder; and

306.18 (4) must return all property held in trust to the client at service termination regardless
306.19 of the client's service termination status, except that:

306.20 (i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section
306.21 609.5316, must be given to the custody of a local law enforcement agency. If giving the
306.22 property to the custody of a local law enforcement agency violates Code of Federal
306.23 Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug
306.24 paraphernalia, or drug container must be destroyed by a staff member designated by the
306.25 program director; and

306.26 (ii) a weapon, explosive, and other property that can cause serious harm to the client or
306.27 others must be given to the custody of a local law enforcement agency, and the client must
306.28 be notified of the transfer and of the client's right to reclaim any lawful property transferred;
306.29 and

306.30 (iii) a medication that was determined by a physician to be harmful after examining the
306.31 client must be destroyed, except when the client's personal physician approves the medication
306.32 for continued use.

307.1 Subd. 4. **Health facility license.** A license holder who provides room and board and
307.2 treatment services in the same facility must have the appropriate license from the Department
307.3 of Health.

307.4 Subd. 5. **Facility abuse prevention plan.** A license holder must establish and enforce
307.5 an ongoing facility abuse prevention plan consistent with sections 245A.65 and 626.557,
307.6 subdivision 14.

307.7 Subd. 6. **Individual abuse prevention plan.** A license holder must prepare an individual
307.8 abuse prevention plan for each client as specified under sections 245A.65, subdivision 2,
307.9 and 626.557, subdivision 14.

307.10 Subd. 7. **Health services.** A license holder must have written procedures for assessing
307.11 and monitoring a client's health, including a standardized data collection tool for collecting
307.12 health-related information about each client. The policies and procedures must be approved
307.13 and signed by a registered nurse.

307.14 Subd. 8. **Administration of medication.** A license holder must meet the administration
307.15 of medications requirements of section 245G.08, subdivision 5, if services include medication
307.16 administration.

307.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

307.18 Sec. 35. **[245G.22] OPIOID TREATMENT PROGRAMS.**

307.19 Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed
307.20 under this chapter must also comply with the requirements of this section and Code of
307.21 Federal Regulations, title 42, part 8. When federal guidance or interpretations are issued on
307.22 federal standards or requirements also required under this section, the federal guidance or
307.23 interpretations shall apply.

307.24 (b) Where a standard in this section differs from a standard in an otherwise applicable
307.25 administrative rule or statute, the standard of this section applies.

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

307.28 (b) "Diversion" means the use of a medication for the treatment of opioid addiction being
307.29 diverted from intended use of the medication.

307.30 (c) "Guest dose" means administration of a medication used for the treatment of opioid
307.31 addiction to a person who is not a client of the program that is administering or dispensing
307.32 the medication.

308.1 (d) "Medical director" means a physician licensed to practice medicine in the jurisdiction
308.2 that the opioid treatment program is located who assumes responsibility for administering
308.3 all medical services performed by the program, either by performing the services directly
308.4 or by delegating specific responsibility to authorized program physicians and health care
308.5 professionals functioning under the medical director's direct supervision.

308.6 (e) "Medication used for the treatment of opioid use disorder" means a medication
308.7 approved by the Food and Drug Administration for the treatment of opioid use disorder.

308.8 (f) "Minnesota health care programs" has the meaning given in section 256B.0636.

308.9 (g) "Opioid treatment program" has the meaning given in Code of Federal Regulations,
308.10 title 42, section 8.12, and includes programs licensed under this chapter.

308.11 (h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605,
308.12 subpart 21a.

308.13 (i) "Unsupervised use" means the use of a medication for the treatment of opioid use
308.14 disorder dispensed for use by a client outside of the program setting.

308.15 Subd. 3. **Medication orders.** Before the program may administer or dispense a medication
308.16 used for the treatment of opioid use disorder:

308.17 (1) a client-specific order must be received from an appropriately credentialed physician
308.18 who is enrolled as a Minnesota health care programs provider and meets all applicable
308.19 provider standards;

308.20 (2) the signed order must be documented in the client's record; and

308.21 (3) if the physician that issued the order is not able to sign the order when issued, the
308.22 unsigned order must be entered in the client record at the time it was received, and the
308.23 physician must review the documentation and sign the order in the client's record within 72
308.24 hours of the medication being ordered. The license holder must report to the commissioner
308.25 any medication error that endangers a client's health, as determined by the medical director.

308.26 Subd. 4. **High dose requirements.** A client being administered or dispensed a dose
308.27 beyond that set forth in subdivision 6, paragraph (a), clause (1), that exceeds 150 milligrams
308.28 of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase,
308.29 must meet face-to-face with a prescribing physician. The meeting must occur before the
308.30 administration or dispensing of the increased medication dose.

308.31 Subd. 5. **Drug testing.** Each client enrolled in the program must receive a minimum of
308.32 eight random drug abuse tests per 12 months of treatment. Drug abuse tests must be

309.1 reasonably disbursed over the 12-month period. A license holder may elect to conduct more
309.2 drug abuse tests.

309.3 Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of
309.4 medication used for the treatment of opioid use disorder to the illicit market, medication
309.5 dispensed to a client for unsupervised use shall be subject to the following requirements:

309.6 (1) any client in an opioid treatment program may receive a single unsupervised use
309.7 dose for a day that the clinic is closed for business, including Sundays and state and federal
309.8 holidays; and

309.9 (2) other treatment program decisions on dispensing medications used for the treatment
309.10 of opioid use disorder to a client for unsupervised use shall be determined by the medical
309.11 director.

309.12 (b) In determining whether a client may be permitted unsupervised use of medications,
309.13 a physician with authority to prescribe must consider the criteria in this paragraph. The
309.14 criteria in this paragraph must also be considered when determining whether dispensing
309.15 medication for a client's unsupervised use is appropriate to increase or to extend the amount
309.16 of time between visits to the program. The criteria are:

309.17 (1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics,
309.18 and alcohol;

309.19 (2) regularity of program attendance;

309.20 (3) absence of serious behavioral problems at the program;

309.21 (4) absence of known recent criminal activity such as drug dealing;

309.22 (5) stability of the client's home environment and social relationships;

309.23 (6) length of time in comprehensive maintenance treatment;

309.24 (7) reasonable assurance that unsupervised use medication will be safely stored within
309.25 the client's home; and

309.26 (8) whether the rehabilitative benefit the client derived from decreasing the frequency
309.27 of program attendance outweighs the potential risks of diversion or unsupervised use.

309.28 (c) The determination, including the basis of the determination must be documented in
309.29 the client's medical record.

309.30 Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a
309.31 physician with authority to prescribe determines that a client meets the criteria in subdivision

310.1 6 and may be dispensed a medication used for the treatment of opioid addiction, the
310.2 restrictions in this subdivision must be followed when the medication to be dispensed is
310.3 methadone hydrochloride.

310.4 (b) During the first 90 days of treatment, the unsupervised use medication supply must
310.5 be limited to a maximum of a single dose each week and the client shall ingest all other
310.6 doses under direct supervision.

310.7 (c) In the second 90 days of treatment, the unsupervised use medication supply must be
310.8 limited to two doses per week.

310.9 (d) In the third 90 days of treatment, the unsupervised use medication supply must not
310.10 exceed three doses per week.

310.11 (e) In the remaining months of the first year, a client may be given a maximum six-day
310.12 unsupervised use medication supply.

310.13 (f) After one year of continuous treatment, a client may be given a maximum two-week
310.14 unsupervised use medication supply.

310.15 (g) After two years of continuous treatment, a client may be given a maximum one-month
310.16 unsupervised use medication supply, but must make monthly visits to the program.

310.17 Subd. 8. **Restriction exceptions.** When a license holder has reason to accelerate the
310.18 number of unsupervised use doses of methadone hydrochloride, the license holder must
310.19 comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the
310.20 criteria for unsupervised use and must use the exception process provided by the federal
310.21 Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the
310.22 purposes of enforcement of this subdivision, the commissioner has the authority to monitor
310.23 a program for compliance with federal regulations and may issue licensing actions according
310.24 to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of
310.25 noncompliance.

310.26 Subd. 9. **Guest dose.** To receive a guest dose, the client must be enrolled in an opioid
310.27 treatment program elsewhere in the state or country and be receiving the medication on a
310.28 temporary basis because the client is not able to receive the medication at the program in
310.29 which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any
310.30 one program and must not be for the convenience or benefit of either program. A guest dose
310.31 may also occur when the client's primary clinic is not open and the client is not receiving
310.32 unsupervised use doses.

311.1 Subd. 10. **Capacity management and waiting list system compliance.** An opioid
311.2 treatment program must notify the department within seven days of the program reaching
311.3 both 90 and 100 percent of the program's capacity to care for clients. Each week, the program
311.4 must report its capacity, currently enrolled dosing clients, and any waiting list. A program
311.5 reporting 90 percent of capacity must also notify the department when the program's census
311.6 increases or decreases from the 90 percent level.

311.7 Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system.
311.8 If the person seeking admission cannot be admitted within 14 days of the date of application,
311.9 each person seeking admission must be placed on the waiting list, unless the person seeking
311.10 admission is assessed by the program and found ineligible for admission according to this
311.11 chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and
311.12 title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each
311.13 person seeking treatment while awaiting admission. A person seeking admission on a waiting
311.14 list who receives no services under section 245G.07, subdivision 1, must not be considered
311.15 a client as defined in section 245G.01, subdivision 9.

311.16 Subd. 12. **Client referral.** An opioid treatment program must consult the capacity
311.17 management system to ensure that a person on a waiting list is admitted at the earliest time
311.18 to a program providing appropriate treatment within a reasonable geographic area. If the
311.19 client was referred through a public payment system and if the program is not able to serve
311.20 the client within 14 days of the date of application for admission, the program must contact
311.21 and inform the referring agency of any available treatment capacity listed in the state capacity
311.22 management system.

311.23 Subd. 13. **Outreach.** An opioid treatment program must carry out activities to encourage
311.24 an individual in need of treatment to undergo treatment. The program's outreach model
311.25 must:

311.26 (1) select, train, and supervise outreach workers;

311.27 (2) contact, communicate, and follow up with individuals with high-risk substance
311.28 misuse, individuals with high-risk substance misuse associates, and neighborhood residents
311.29 within the constraints of federal and state confidentiality requirements;

311.30 (3) promote awareness among individuals who engage in substance misuse by injection
311.31 about the relationship between injecting substances and communicable diseases such as
311.32 HIV; and

311.33 (4) recommend steps to prevent HIV transmission.

312.1 Subd. 14. **Central registry.** (a) A license holder must comply with requirements to
 312.2 submit information and necessary consents to the state central registry for each client
 312.3 admitted, as specified by the commissioner. The license holder must submit data concerning
 312.4 medication used for the treatment of opioid use disorder. The data must be submitted in a
 312.5 method determined by the commissioner and the original information must be kept in the
 312.6 client's record. The information must be submitted for each client at admission and discharge.
 312.7 The program must document the date the information was submitted. The client's failure to
 312.8 provide the information shall prohibit participation in an opioid treatment program. The
 312.9 information submitted must include the client's:

312.10 (1) full name and all aliases;

312.11 (2) date of admission;

312.12 (3) date of birth;

312.13 (4) Social Security number or Alien Registration Number, if any;

312.14 (5) current or previous enrollment status in another opioid treatment program;

312.15 (6) government-issued photo identification card number; and

312.16 (7) driver's license number, if any.

312.17 (b) The requirements in paragraph (a) are effective upon the commissioner's
 312.18 implementation of changes to the drug and alcohol abuse normative evaluation system or
 312.19 development of an electronic system by which to submit the data.

312.20 Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must
 312.21 offer at least 50 consecutive minutes of individual or group therapy treatment services as
 312.22 defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first
 312.23 ten weeks following admission, and at least 50 consecutive minutes per month thereafter.
 312.24 As clinically appropriate, the program may offer these services cumulatively and not
 312.25 consecutively in increments of no less than 15 minutes over the required time period, and
 312.26 for a total of 60 minutes of treatment services over the time period, and must document the
 312.27 reason for providing services cumulatively in the client's record. The program may offer
 312.28 additional levels of service when deemed clinically necessary.

312.29 (b) Notwithstanding the requirements of comprehensive assessments in section 245G.05,
 312.30 the assessment must be completed within 21 days of service initiation.

312.31 (c) Notwithstanding the requirements of individual treatment plans set forth in section
 312.32 245G.06:

313.1 (1) treatment plan contents for a maintenance client are not required to include goals
313.2 the client must reach to complete treatment and have services terminated;

313.3 (2) treatment plans for a client in a taper or detox status must include goals the client
313.4 must reach to complete treatment and have services terminated;

313.5 (3) for the initial ten weeks after admission for all new admissions, readmissions, and
313.6 transfers, progress notes must be entered in a client's file at least weekly and be recorded
313.7 in each of the six dimensions upon the development of the treatment plan and thereafter.
313.8 Subsequently, the counselor must document progress in the six dimensions at least once
313.9 monthly or, when clinical need warrants, more frequently; and

313.10 (4) upon the development of the treatment plan and thereafter, treatment plan reviews
313.11 must occur weekly, or after each treatment service, whichever is less frequent, for the first
313.12 ten weeks after the treatment plan is developed. Following the first ten weeks of treatment
313.13 plan reviews, reviews may occur monthly, unless the client's needs warrant more frequent
313.14 revisions or documentation.

313.15 Subd. 16. **Prescription monitoring program.** (a) The program must develop and
313.16 maintain a policy and procedure that requires the ongoing monitoring of the data from the
313.17 prescription monitoring program (PMP) for each client. The policy and procedure must
313.18 include how the program meets the requirements in paragraph (b).

313.19 (b) If a medication used for the treatment of substance use disorder is administered or
313.20 dispensed to a client, the license holder shall be subject to the following requirements:

313.21 (1) upon admission to a methadone clinic outpatient treatment program, a client must
313.22 be notified in writing that the commissioner of human services and the medical director
313.23 must monitor the PMP to review the prescribed controlled drugs a client received;

313.24 (2) the medical director or the medical director's delegate must review the data from the
313.25 PMP described in section 152.126 before the client is ordered any controlled substance, as
313.26 defined under section 152.126, subdivision 1, paragraph (c), including medications used
313.27 for the treatment of opioid addiction, and the medical director's or the medical director's
313.28 delegate's subsequent reviews of the PMP data must occur at least every 90 days;

313.29 (3) a copy of the PMP data reviewed must be maintained in the client's file;

313.30 (4) when the PMP data contains a recent history of multiple prescribers or multiple
313.31 prescriptions for controlled substances, the physician's review of the data and subsequent
313.32 actions must be documented in the client's file within 72 hours and must contain the medical
313.33 director's determination of whether or not the prescriptions place the client at risk of harm

314.1 and the actions to be taken in response to the PMP findings. The provider must conduct
314.2 subsequent reviews of the PMP on a monthly basis; and

314.3 (5) if at any time the medical director believes the use of the controlled substances places
314.4 the client at risk of harm, the program must seek the client's consent to discuss the client's
314.5 opioid treatment with other prescribers and must seek the client's consent for the other
314.6 prescriber to disclose to the opioid treatment program's medical director the client's condition
314.7 that formed the basis of the other prescriptions. If the information is not obtained within
314.8 seven days, the medical director must document whether or not changes to the client's
314.9 medication dose or number of unsupervised use doses are necessary until the information
314.10 is obtained.

314.11 (c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop
314.12 and implement an electronic system for the commissioner to routinely access the PMP data
314.13 to determine whether any client enrolled in an opioid addiction treatment program licensed
314.14 according to this section was prescribed or dispensed a controlled substance in addition to
314.15 that administered or dispensed by the opioid addiction treatment program. When the
314.16 commissioner determines there have been multiple prescribers or multiple prescriptions of
314.17 controlled substances for a client, the commissioner shall:

314.18 (1) inform the medical director of the opioid treatment program only that the
314.19 commissioner determined the existence of multiple prescribers or multiple prescriptions of
314.20 controlled substances; and

314.21 (2) direct the medical director of the opioid treatment program to access the data directly,
314.22 review the effect of the multiple prescribers or multiple prescriptions, and document the
314.23 review.

314.24 (d) If determined necessary, the commissioner shall seek a federal waiver of, or exception
314.25 to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), before
314.26 implementing this subdivision.

314.27 Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the
314.28 policies and procedures required in this subdivision.

314.29 (b) For a program that is not open every day of the year, the license holder must maintain
314.30 a policy and procedure that permits a client to receive a single unsupervised use of medication
314.31 used for the treatment of opioid use disorder for days that the program is closed for business,
314.32 including, but not limited to, Sundays and state and federal holidays as required under
314.33 subdivision 6, paragraph (a), clause (1).

315.1 (c) The license holder must maintain a policy and procedure that includes specific
315.2 measures to reduce the possibility of diversion. The policy and procedure must:

315.3 (1) specifically identify and define the responsibilities of the medical and administrative
315.4 staff for performing diversion control measures; and

315.5 (2) include a process for contacting no less than five percent of clients who have
315.6 unsupervised use of medication, excluding clients approved solely under subdivision 6,
315.7 paragraph (a), clause (1), to require clients to physically return to the program each month.
315.8 The system must require clients to return to the program within a stipulated time frame and
315.9 turn in all unused medication containers related to opioid use disorder treatment. The license
315.10 holder must document all related contacts on a central log and the outcome of the contact
315.11 for each client in the client's record.

315.12 (d) Medication used for the treatment of opioid use disorder must be ordered,
315.13 administered, and dispensed according to applicable state and federal regulations and the
315.14 standards set by applicable accreditation entities. If a medication order requires assessment
315.15 by the person administering or dispensing the medication to determine the amount to be
315.16 administered or dispensed, the assessment must be completed by an individual whose
315.17 professional scope of practice permits an assessment. For the purposes of enforcement of
315.18 this paragraph, the commissioner has the authority to monitor the person administering or
315.19 dispensing the medication for compliance with state and federal regulations and the relevant
315.20 standards of the license holder's accreditation agency and may issue licensing actions
315.21 according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's
315.22 determination of noncompliance.

315.23 Subd. 18. **Quality improvement plan.** The license holder must develop and maintain
315.24 a quality improvement plan that:

315.25 (1) includes evaluation of the services provided to clients to identify issues that may
315.26 improve service delivery and client outcomes;

315.27 (2) includes goals for the program to accomplish based on the evaluation;

315.28 (3) is reviewed annually by the management of the program to determine whether the
315.29 goals were met and, if not, whether additional action is required;

315.30 (4) is updated at least annually to include new or continued goals based on an updated
315.31 evaluation of services; and

315.32 (5) identifies two specific goal areas, in addition to others identified by the program,
315.33 including:

316.1 (i) a goal concerning oversight and monitoring of the premises around and near the
316.2 exterior of the program to reduce the possibility of medication used for the treatment of
316.3 opioid use disorder being inappropriately used by a client, including but not limited to the
316.4 sale or transfer of the medication to others; and

316.5 (ii) a goal concerning community outreach, including but not limited to communications
316.6 with local law enforcement and county human services agencies, to increase coordination
316.7 of services and identification of areas of concern to be addressed in the plan.

316.8 Subd. 19. **Placing authorities.** A program must provide certain notification and
316.9 client-specific updates to placing authorities for a client who is enrolled in Minnesota health
316.10 care programs. At the request of the placing authority, the program must provide
316.11 client-specific updates, including but not limited to informing the placing authority of
316.12 positive drug screenings and changes in medications used for the treatment of opioid use
316.13 disorder ordered for the client.

316.14 Subd. 20. **Duty to report suspected drug diversion.** (a) To the fullest extent permitted
316.15 under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to
316.16 law enforcement any credible evidence that the program or its personnel knows, or reasonably
316.17 should know, that is directly related to a diversion crime on the premises of the program,
316.18 or a threat to commit a diversion crime.

316.19 (b) "Diversion crime," for the purposes of this section, means diverting, attempting to
316.20 divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02,
316.21 on the program's premises.

316.22 (c) The program must document the program's compliance with the requirement in
316.23 paragraph (a) in either a client's record or an incident report. A program's failure to comply
316.24 with paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

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

316.26 Sec. 36. Minnesota Statutes 2016, section 246.18, subdivision 4, is amended to read:

316.27 Subd. 4. **Collections deposited in the general fund.** Except as provided in subdivisions
316.28 5, 6, and 7, all receipts from collection efforts for the regional treatment centers, state nursing
316.29 homes; and other state facilities as defined in section 246.50, subdivision 3, must be deposited
316.30 in the general fund. From that amount, receipts from collection efforts for the Anoka-Metro
316.31 Regional Treatment Center and community behavioral health hospitals must be deposited
316.32 in accordance with subdivision 4a. The commissioner shall ensure that the departmental
316.33 financial reporting systems and internal accounting procedures comply with federal standards

317.1 for reimbursement for program and administrative expenditures and fulfill the purpose of
317.2 this ~~paragraph~~ subdivision.

317.3 Sec. 37. Minnesota Statutes 2016, section 246.18, is amended by adding a subdivision to
317.4 read:

317.5 Subd. 4a. **Mental health innovation account.** The mental health innovation account is
317.6 established in the special revenue fund. Beginning in fiscal year 2018, \$1,000,000 of the
317.7 revenue generated by collection efforts from the Anoka-Metro Regional Treatment Center
317.8 and community behavioral health hospitals under section 246.54 must annually be deposited
317.9 into the mental health innovation account. Money deposited in the mental health innovation
317.10 account is appropriated to the commissioner of human services for the mental health
317.11 innovation grant program under section 245.4662.

317.12 Sec. 38. Minnesota Statutes 2016, section 254A.01, is amended to read:

317.13 **254A.01 PUBLIC POLICY.**

317.14 It is hereby declared to be the public policy of this state that scientific evidence shows
317.15 that addiction to alcohol or other drugs is a chronic brain disorder with potential for
317.16 recurrence, and as with many other chronic conditions, people with substance use disorders
317.17 can be effectively treated and can enter recovery. The interests of society are best served
317.18 by reducing the stigma of substance use disorder and providing persons who are dependent
317.19 upon alcohol or other drugs with a comprehensive range of rehabilitative and social services
317.20 that span intensity levels and are not restricted to a particular point in time. Further, it is
317.21 declared that treatment under these services shall be voluntary when possible: treatment
317.22 shall not be denied on the basis of prior treatment; treatment shall be based on an individual
317.23 treatment plan for each person undergoing treatment; treatment shall include a continuum
317.24 of services available for a person leaving a program of treatment; treatment shall include
317.25 all family members at the earliest possible phase of the treatment process.

317.26 **EFFECTIVE DATE.** This section is effective January 1, 2018.

317.27 Sec. 39. Minnesota Statutes 2016, section 254A.02, subdivision 2, is amended to read:

317.28 Subd. 2. **Approved treatment program.** "Approved treatment program" means care
317.29 and treatment services provided by any individual, organization or association to ~~drug~~
317.30 ~~dependent~~ persons with a substance use disorder, which meets the standards established by
317.31 the commissioner of human services.

317.32 **EFFECTIVE DATE.** This section is effective January 1, 2018.

318.1 Sec. 40. Minnesota Statutes 2016, section 254A.02, subdivision 3, is amended to read:

318.2 Subd. 3. **Comprehensive program.** "Comprehensive program" means the range of
318.3 services which are to be made available for the purpose of prevention, care and treatment
318.4 of ~~alcohol and drug abuse~~ substance misuse and substance use disorder.

318.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

318.6 Sec. 41. Minnesota Statutes 2016, section 254A.02, subdivision 5, is amended to read:

318.7 Subd. 5. **Drug dependent person.** "Drug dependent person" means any ~~inebriate person~~
318.8 ~~or any~~ person incapable of self-management or management of personal affairs or unable
318.9 to function physically or mentally in an effective manner because of the abuse of a drug,
318.10 including alcohol.

318.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

318.12 Sec. 42. Minnesota Statutes 2016, section 254A.02, subdivision 6, is amended to read:

318.13 Subd. 6. **Facility.** "Facility" means any treatment facility administered under an approved
318.14 treatment program ~~established under Laws 1973, chapter 572.~~

318.15 **EFFECTIVE DATE.** This section is effective January 1, 2018.

318.16 Sec. 43. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision
318.17 to read:

318.18 Subd. 6a. **Substance misuse.** "Substance misuse" means the use of any psychoactive
318.19 or mood-altering substance, without compelling medical reason, in a manner that results in
318.20 mental, emotional, or physical impairment and causes socially dysfunctional or socially
318.21 disordering behavior and that results in psychological dependence or physiological addiction
318.22 as a function of continued use. Substance misuse has the same meaning as drug abuse or
318.23 abuse of drugs.

318.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

318.25 Sec. 44. Minnesota Statutes 2016, section 254A.02, subdivision 8, is amended to read:

318.26 Subd. 8. **Other drugs.** "Other drugs" means any psychoactive ~~chemical~~ substance other
318.27 than alcohol.

318.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

319.1 Sec. 45. Minnesota Statutes 2016, section 254A.02, subdivision 10, is amended to read:

319.2 Subd. 10. **State authority.** "State authority" is a division established within the
 319.3 Department of Human Services for the purpose of relating the authority of state government
 319.4 in the area of ~~alcohol and drug abuse~~ substance misuse and substance use disorder to the
 319.5 ~~alcohol and drug abuse~~ substance misuse and substance use disorder-related activities within
 319.6 the state.

319.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

319.8 Sec. 46. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision
 319.9 to read:

319.10 Subd. 10a. **Substance use disorder.** "Substance use disorder" has the meaning given
 319.11 in the current Diagnostic and Statistical Manual of Mental Disorders.

319.12 **EFFECTIVE DATE.** This section is effective January 1, 2018.

319.13 Sec. 47. Minnesota Statutes 2016, section 254A.03, is amended to read:

319.14 **254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.**

319.15 Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an
 319.16 Alcohol and Other Drug Abuse Section in the Department of Human Services. This section
 319.17 shall be headed by a director. The commissioner may place the director's position in the
 319.18 unclassified service if the position meets the criteria established in section 43A.08,
 319.19 subdivision 1a. The section shall:

319.20 (1) conduct and foster basic research relating to the cause, prevention and methods of
 319.21 diagnosis, treatment and rehabilitation of ~~alcoholic and other drug dependent~~ persons with
 319.22 substance misuse and substance use disorder;

319.23 (2) coordinate and review all activities and programs of all the various state departments
 319.24 as they relate to ~~alcohol and other drug dependency and abuse~~ problems associated with
 319.25 substance misuse and substance use disorder;

319.26 (3) develop, demonstrate, and disseminate new methods and techniques for ~~the~~ prevention,
 319.27 early intervention, treatment and ~~rehabilitation of alcohol and other drug abuse and~~
 319.28 ~~dependency problems~~ recovery support for substance misuse and substance use disorder;

319.29 (4) gather facts and information about ~~alcoholism and other drug dependency and abuse~~
 319.30 substance misuse and substance use disorder, and about the efficiency and effectiveness of
 319.31 prevention, treatment, and ~~rehabilitation~~ recovery support services from all comprehensive

320.1 programs, including programs approved or licensed by the commissioner of human services
320.2 or the commissioner of health or accredited by the Joint Commission on Accreditation of
320.3 Hospitals. The state authority is authorized to require information from comprehensive
320.4 programs which is reasonable and necessary to fulfill these duties. When required information
320.5 has been previously furnished to a state or local governmental agency, the state authority
320.6 shall collect the information from the governmental agency. The state authority shall
320.7 disseminate facts and summary information about ~~alcohol and other drug abuse dependency~~
320.8 problems associated with substance misuse and substance use disorder to public and private
320.9 agencies, local governments, local and regional planning agencies, and the courts for guidance
320.10 to and assistance in prevention, treatment and ~~rehabilitation~~ recovery support;

320.11 (5) inform and educate the general public on ~~alcohol and other drug dependency and~~
320.12 ~~abuse problems~~ substance misuse and substance use disorder;

320.13 (6) serve as the state authority concerning ~~alcohol and other drug dependency and abuse~~
320.14 substance misuse and substance use disorder by monitoring the conduct of diagnosis and
320.15 referral services, research and comprehensive programs. The state authority shall submit a
320.16 biennial report to the governor and the legislature containing a description of public services
320.17 delivery and recommendations concerning increase of coordination and quality of services,
320.18 and decrease of service duplication and cost;

320.19 (7) establish a state plan which shall set forth goals and priorities for a comprehensive
320.20 ~~alcohol and other drug dependency and abuse program~~ continuum of care for substance
320.21 misuse and substance use disorder for Minnesota. All state agencies operating ~~alcohol and~~
320.22 ~~other drug abuse or dependency~~ substance misuse or substance use disorder programs or
320.23 administering state or federal funds for such programs shall annually set their program goals
320.24 and priorities in accordance with the state plan. Each state agency shall annually submit its
320.25 plans and budgets to the state authority for review. The state authority shall certify whether
320.26 proposed services comply with the comprehensive state plan and advise each state agency
320.27 of review findings;

320.28 (8) make contracts with and grants to public and private agencies and organizations,
320.29 both profit and nonprofit, and individuals, using federal funds, and state funds as authorized
320.30 to pay for costs of state administration, including evaluation, statewide programs and services,
320.31 research and demonstration projects, and American Indian programs;

320.32 (9) receive and administer ~~monies~~ money available for ~~alcohol and drug abuse~~ substance
320.33 misuse and substance use disorder programs under the alcohol, drug abuse, and mental
320.34 health services block grant, United States Code, title 42, sections 300X to 300X-9;

321.1 (10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter
 321.2 572, and any grant of money, services, or property from the federal government, the state,
 321.3 any political subdivision thereof, or any private source;

321.4 (11) with respect to ~~alcohol and other drug abuse~~ substance misuse and substance use
 321.5 disorder programs serving the American Indian community, establish guidelines for the
 321.6 employment of personnel with considerable practical experience in ~~alcohol and other drug~~
 321.7 ~~abuse problems~~ substance misuse and substance use disorder, and understanding of social
 321.8 and cultural problems related to ~~alcohol and other drug abuse~~ substance misuse and substance
 321.9 use disorder, in the American Indian community.

321.10 Subd. 2. **American Indian programs.** There is hereby created a section of American
 321.11 Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human
 321.12 Services, to be headed by a special assistant for American Indian programs on ~~alcoholism~~
 321.13 ~~and drug abuse~~ substance misuse and substance use disorder and two assistants to that
 321.14 position. The section shall be staffed with all personnel necessary to fully administer
 321.15 programming for ~~alcohol and drug abuse~~ substance misuse and substance use disorder
 321.16 services for American Indians in the state. The special assistant position shall be filled by
 321.17 a person with considerable practical experience in and understanding of ~~alcohol and other~~
 321.18 ~~drug abuse problems~~ substance misuse and substance use disorder in the American Indian
 321.19 community, who shall be responsible to the director of the Alcohol and Drug Abuse Section
 321.20 created in subdivision 1 and shall be in the unclassified service. The special assistant shall
 321.21 meet and consult with the American Indian Advisory Council as described in section
 321.22 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report
 321.23 on the status of ~~alcohol and other drug abuse~~ substance misuse and substance use disorder
 321.24 among American Indians in the state of Minnesota. The special assistant with the approval
 321.25 of the director shall:

321.26 (1) administer funds appropriated for American Indian groups, organizations and
 321.27 reservations within the state for American Indian ~~alcoholism and drug abuse~~ substance
 321.28 misuse and substance use disorder programs;

321.29 (2) establish policies and procedures for such American Indian programs with the
 321.30 assistance of the American Indian Advisory Board; and

321.31 (3) hire and supervise staff to assist in the administration of the American Indian program
 321.32 section within the Alcohol and Drug Abuse Section of the Department of Human Services.

321.33 Subd. 3. **Rules for ~~chemical dependency~~ substance use disorder care.** (a) The
 321.34 commissioner of human services shall establish by rule criteria to be used in determining

322.1 the appropriate level of chemical dependency care for each recipient of public assistance
 322.2 seeking treatment for ~~alcohol or other drug dependency and abuse problems~~. substance
 322.3 misuse or substance use disorder. Upon federal approval of a comprehensive assessment
 322.4 as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria
 322.5 in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive
 322.6 assessments under section 254B.05 may determine and approve the appropriate level of
 322.7 substance use disorder treatment for a recipient of public assistance. The process for
 322.8 determining an individual's financial eligibility for the consolidated chemical dependency
 322.9 treatment fund or determining an individual's enrollment in or eligibility for a publicly
 322.10 subsidized health plan is not affected by the individual's choice to access a comprehensive
 322.11 assessment for placement.

322.12 (b) The commissioner shall develop and implement a utilization review process for
 322.13 publicly funded treatment placements to monitor and review the clinical appropriateness
 322.14 and timeliness of all publicly funded placements in treatment.

322.15 **EFFECTIVE DATE.** This section is effective January 1, 2018.

322.16 Sec. 48. Minnesota Statutes 2016, section 254A.035, subdivision 1, is amended to read:

322.17 Subdivision 1. **Establishment.** There is created an American Indian Advisory Council
 322.18 to assist the state authority on ~~alcohol and drug abuse~~ substance misuse and substance use
 322.19 disorder in proposal review and formulating policies and procedures relating to ~~chemical~~
 322.20 ~~dependency and the abuse of alcohol and other drugs~~ substance misuse and substance use
 322.21 disorder by American Indians.

322.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

322.23 Sec. 49. Minnesota Statutes 2016, section 254A.04, is amended to read:

322.24 **254A.04 CITIZENS ADVISORY COUNCIL.**

322.25 There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise
 322.26 the Department of Human Services concerning the problems of ~~alcohol and other drug~~
 322.27 ~~dependency and abuse~~ substance misuse and substance use disorder, composed of ten
 322.28 members. Five members shall be individuals whose interests or training are in the field of
 322.29 ~~alcohol dependency~~ alcohol-specific substance use disorder and ~~abuse~~ alcohol misuse; and
 322.30 five members whose interests or training are in the field of ~~dependency~~ substance use
 322.31 disorder and ~~abuse of drugs~~ misuse of substances other than alcohol. The terms, compensation
 322.32 and removal of members shall be as provided in section 15.059. The council expires June

323.1 30, 2018. The commissioner of human services shall appoint members whose terms end in
 323.2 even-numbered years. The commissioner of health shall appoint members whose terms end
 323.3 in odd-numbered years.

323.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

323.5 Sec. 50. Minnesota Statutes 2016, section 254A.08, is amended to read:

323.6 **254A.08 DETOXIFICATION CENTERS.**

323.7 Subdivision 1. **Detoxification services.** Every county board shall provide detoxification
 323.8 services for ~~drug dependent persons~~ any person incapable of self-management or management
 323.9 of personal affairs or unable to function physically or mentally in an effective manner
 323.10 because of the use of a drug, including alcohol. The board may utilize existing treatment
 323.11 programs and other agencies to meet this responsibility.

323.12 Subd. 2. **Program requirements.** For the purpose of this section, a detoxification
 323.13 program means a social rehabilitation program licensed by the Department of Human
 323.14 Services under chapter 245A, and governed by the standards of Minnesota Rules, parts
 323.15 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and
 323.16 treatment by detoxifying and evaluating the person and providing entrance into a
 323.17 comprehensive program. Evaluation of the person shall include verification by a professional,
 323.18 after preliminary examination, that the person is intoxicated or has symptoms of ~~chemical~~
 323.19 ~~dependency~~ substance misuse or substance use disorder and appears to be in imminent
 323.20 danger of harming self or others. A detoxification program shall have available the services
 323.21 of a licensed physician for medical emergencies and routine medical surveillance. A
 323.22 detoxification program licensed by the Department of Human Services to serve both adults
 323.23 and minors at the same site must provide for separate sleeping areas for adults and minors.

323.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

323.25 Sec. 51. Minnesota Statutes 2016, section 254A.09, is amended to read:

323.26 **254A.09 CONFIDENTIALITY OF RECORDS.**

323.27 The Department of Human Services shall assure confidentiality to individuals who are
 323.28 the subject of research by the state authority or are recipients of ~~alcohol or drug abuse~~
 323.29 substance misuse or substance use disorder information, assessment, or treatment from a
 323.30 licensed or approved program. The commissioner shall withhold from all persons not
 323.31 connected with the conduct of the research the names or other identifying characteristics
 323.32 of a subject of research unless the individual gives written permission that information

324.1 relative to treatment and recovery may be released. Persons authorized to protect the privacy
 324.2 of subjects of research may not be compelled in any federal, state or local, civil, criminal,
 324.3 administrative or other proceeding to identify or disclose other confidential information
 324.4 about the individuals. Identifying information and other confidential information related to
 324.5 ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment,
 324.6 treatment, or aftercare services may be ordered to be released by the court for the purpose
 324.7 of civil or criminal investigations or proceedings if, after review of the records considered
 324.8 for disclosure, the court determines that the information is relevant to the purpose for which
 324.9 disclosure is requested. The court shall order disclosure of only that information which is
 324.10 determined relevant. In determining whether to compel disclosure, the court shall weigh
 324.11 the public interest and the need for disclosure against the injury to the patient, to the treatment
 324.12 relationship in the program affected and in other programs similarly situated, and the actual
 324.13 or potential harm to the ability of programs to attract and retain patients if disclosure occurs.
 324.14 This section does not exempt any person from the reporting obligations under section
 324.15 626.556, nor limit the use of information reported in any proceeding arising out of the abuse
 324.16 or neglect of a child. Identifying information and other confidential information related to
 324.17 ~~alcohol or drug abuse information~~ substance misuse or substance use disorder, assessment,
 324.18 treatment, or aftercare services may be ordered to be released by the court for the purpose
 324.19 of civil or criminal investigations or proceedings. No information may be released pursuant
 324.20 to this section that would not be released pursuant to section 595.02, subdivision 2.

324.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

324.22 Sec. 52. Minnesota Statutes 2016, section 254A.19, subdivision 3, is amended to read:

324.23 Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b) or (c),
 324.24 or (d), an assessor conducting a chemical use assessment under Minnesota Rules, parts
 324.25 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral
 324.26 relationship resulting in shared financial gain with a treatment provider.

324.27 (b) A county may contract with an assessor having a conflict described in paragraph (a)
 324.28 if the county documents that:

324.29 (1) the assessor is employed by a culturally specific service provider or a service provider
 324.30 with a program designed to treat individuals of a specific age, sex, or sexual preference;

324.31 (2) the county does not employ a sufficient number of qualified assessors and the only
 324.32 qualified assessors available in the county have a direct or shared financial interest or a
 324.33 referral relationship resulting in shared financial gain with a treatment provider; or

325.1 (3) the county social service agency has an existing relationship with an assessor or
 325.2 service provider and elects to enter into a contract with that assessor to provide both
 325.3 assessment and treatment under circumstances specified in the county's contract, provided
 325.4 the county retains responsibility for making placement decisions.

325.5 (c) The county may contract with a hospital to conduct chemical assessments if the
 325.6 requirements in subdivision 1a are met.

325.7 An assessor under this paragraph may not place clients in treatment. The assessor shall
 325.8 gather required information and provide it to the county along with any required
 325.9 documentation. The county shall make all placement decisions for clients assessed by
 325.10 assessors under this paragraph.

325.11 (d) An eligible vendor under section 254B.05 conducting a comprehensive assessment
 325.12 for an individual seeking treatment shall approve the nature, intensity level, and duration
 325.13 of treatment service if a need for services is indicated, but the individual assessed can access
 325.14 any enrolled provider that is licensed to provide the level of service authorized, including
 325.15 the provider or program that completed the assessment. If an individual is enrolled in a
 325.16 prepaid health plan, the individual must comply with any provider network requirements
 325.17 or limitations.

325.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

325.19 Sec. 53. Minnesota Statutes 2016, section 254B.01, subdivision 3, is amended to read:

325.20 Subd. 3. ~~Chemical dependency~~ **Substance use disorder treatment services.** "Chemical
 325.21 ~~dependency~~ Substance use disorder treatment services" means a planned program of care
 325.22 for the treatment of ~~chemical dependency~~ substance misuse or ~~chemical abuse~~ substance
 325.23 use disorder to minimize or prevent further ~~chemical abuse~~ substance misuse by the person.
 325.24 Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services that are
 325.25 not part of a program of care licensable as a residential or nonresidential ~~chemical dependency~~
 325.26 substance use disorder treatment program are not ~~chemical dependency~~ substance use
 325.27 disorder services for purposes of this section. For pregnant and postpartum women, ~~chemical~~
 325.28 ~~dependency~~ substance use disorder services include halfway house services, aftercare
 325.29 services, psychological services, and case management.

325.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

326.1 Sec. 54. Minnesota Statutes 2016, section 254B.01, is amended by adding a subdivision
326.2 to read:

326.3 Subd. 8. **Recovery community organization.** "Recovery community organization"
326.4 means an independent organization led and governed by representatives of local communities
326.5 of recovery. A recovery community organization mobilizes resources within and outside
326.6 of the recovery community to increase the prevalence and quality of long-term recovery
326.7 from alcohol and other drug addiction. Recovery community organizations provide
326.8 peer-based recovery support activities such as training of recovery peers. Recovery
326.9 community organizations provide mentorship and ongoing support to individuals dealing
326.10 with a substance use disorder and connect them with the resources that can support each
326.11 person's recovery. A recovery community organization also promotes a recovery-focused
326.12 orientation in community education and outreach programming, and organize
326.13 recovery-focused policy advocacy activities to foster healthy communities and reduce the
326.14 stigma of substance use disorder.

326.15 **EFFECTIVE DATE.** This section is effective January 1, 2018.

326.16 Sec. 55. Minnesota Statutes 2016, section 254B.03, subdivision 2, is amended to read:

326.17 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
326.18 dependency fund is limited to payments for services other than detoxification licensed under
326.19 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
326.20 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
326.21 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
326.22 services other than detoxification provided in another state that would be required to be
326.23 licensed as a chemical dependency program if the program were in the state. Out of state
326.24 vendors must also provide the commissioner with assurances that the program complies
326.25 substantially with state licensing requirements and possesses all licenses and certifications
326.26 required by the host state to provide chemical dependency treatment. ~~Except for chemical~~
326.27 ~~dependency transitional rehabilitation programs,~~ Vendors receiving payments from the
326.28 chemical dependency fund must not require co-payment from a recipient of benefits for
326.29 services provided under this subdivision. The vendor is prohibited from using the client's
326.30 public benefits to offset the cost of services paid under this section. The vendor shall not
326.31 require the client to use public benefits for room or board costs. This includes but is not
326.32 limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits.
326.33 Retention of SNAP benefits is a right of a client receiving services through the consolidated
326.34 chemical dependency treatment fund or through state contracted managed care entities.

327.1 Payment from the chemical dependency fund shall be made for necessary room and board
327.2 costs provided by vendors certified according to section 254B.05, or in a community hospital
327.3 licensed by the commissioner of health according to sections 144.50 to 144.56 to a client
327.4 who is:

327.5 (1) determined to meet the criteria for placement in a residential chemical dependency
327.6 treatment program according to rules adopted under section 254A.03, subdivision 3; and

327.7 (2) concurrently receiving a chemical dependency treatment service in a program licensed
327.8 by the commissioner and reimbursed by the chemical dependency fund.

327.9 (b) A county may, from its own resources, provide chemical dependency services for
327.10 which state payments are not made. A county may elect to use the same invoice procedures
327.11 and obtain the same state payment services as are used for chemical dependency services
327.12 for which state payments are made under this section if county payments are made to the
327.13 state in advance of state payments to vendors. When a county uses the state system for
327.14 payment, the commissioner shall make monthly billings to the county using the most recent
327.15 available information to determine the anticipated services for which payments will be made
327.16 in the coming month. Adjustment of any overestimate or underestimate based on actual
327.17 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
327.18 month.

327.19 (c) The commissioner shall coordinate chemical dependency services and determine
327.20 whether there is a need for any proposed expansion of chemical dependency treatment
327.21 services. The commissioner shall deny vendor certification to any provider that has not
327.22 received prior approval from the commissioner for the creation of new programs or the
327.23 expansion of existing program capacity. The commissioner shall consider the provider's
327.24 capacity to obtain clients from outside the state based on plans, agreements, and previous
327.25 utilization history, when determining the need for new treatment services.

327.26 **EFFECTIVE DATE.** This section is effective January 1, 2018.

327.27 Sec. 56. Minnesota Statutes 2016, section 254B.04, subdivision 1, is amended to read:

327.28 Subdivision 1. **Eligibility.** ~~(a)~~ Persons eligible for benefits under Code of Federal
327.29 Regulations, title 25, part 20, and persons eligible for medical assistance benefits under
327.30 sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the
327.31 income standards of section 256B.056, subdivision 4, are entitled to chemical dependency
327.32 fund services. State money appropriated for this paragraph must be placed in a separate
327.33 account established for this purpose.

328.1 Persons with dependent children who are determined to be in need of chemical
 328.2 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
 328.3 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
 328.4 local agency to access needed treatment services. Treatment services must be appropriate
 328.5 for the individual or family, which may include long-term care treatment or treatment in a
 328.6 facility that allows the dependent children to stay in the treatment facility. The county shall
 328.7 pay for out-of-home placement costs, if applicable.

328.8 ~~(b) A person not entitled to services under paragraph (a), but with family income that~~
 328.9 ~~is less than 215 percent of the federal poverty guidelines for the applicable family size, shall~~
 328.10 ~~be eligible to receive chemical dependency fund services within the limit of funds~~
 328.11 ~~appropriated for this group for the fiscal year. If notified by the state agency of limited~~
 328.12 ~~funds, a county must give preferential treatment to persons with dependent children who~~
 328.13 ~~are in need of chemical dependency treatment pursuant to an assessment under section~~
 328.14 ~~626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212.~~
 328.15 ~~A county may spend money from its own sources to serve persons under this paragraph.~~
 328.16 ~~State money appropriated for this paragraph must be placed in a separate account established~~
 328.17 ~~for this purpose.~~

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

328.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

328.26 Sec. 57. Minnesota Statutes 2016, section 254B.04, subdivision 2b, is amended to read:

328.27 Subd. 2b. **Eligibility for placement in opioid treatment programs.** ~~(a) Notwithstanding~~
 328.28 ~~provisions of Minnesota Rules, part 9530.6622, subpart 5, related to a placement authority's~~
 328.29 ~~requirement to authorize services or service coordination in a program that complies with~~
 328.30 ~~Minnesota Rules, part 9530.6500, or Code of Federal Regulations, title 42, part 8, and after~~
 328.31 ~~taking into account an individual's preference for placement in an opioid treatment program,~~
 328.32 ~~a placement authority may, but is not required to, authorize services or service coordination~~
 328.33 ~~or otherwise place an individual in an opioid treatment program. Prior to making a~~

329.1 ~~determination of placement for an individual, the placing authority must consult with the~~
329.2 ~~current treatment provider, if any.~~

329.3 (b) Prior to placement of an individual who is determined by the assessor to require
329.4 treatment for opioid addiction, the assessor must provide educational information concerning
329.5 treatment options for opioid addiction, including the use of a medication for the use of
329.6 opioid addiction. The commissioner shall develop educational materials supported by
329.7 research and updated periodically that must be used by assessors to comply with this
329.8 requirement.

329.9 **EFFECTIVE DATE.** This section is effective January 1, 2018.

329.10 Sec. 58. Minnesota Statutes 2016, section 254B.05, subdivision 1, is amended to read:

329.11 Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are
329.12 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
329.13 notwithstanding the provisions of section 245A.03. American Indian programs that provide
329.14 ~~chemical dependency primary~~ substance use disorder treatment, extended care, transitional
329.15 residence, or outpatient treatment services, and are licensed by tribal government are eligible
329.16 vendors.

329.17 (b) On July 1, 2018, or upon federal approval, whichever is later, a licensed professional
329.18 in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4,
329.19 is an eligible vendor of a comprehensive assessment and assessment summary provided
329.20 according to section 245G.05, and treatment services provided according to sections 245G.06
329.21 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

329.22 (c) On July 1, 2018, or upon federal approval, whichever is later, a county is an eligible
329.23 vendor for a comprehensive assessment and assessment summary when provided by an
329.24 individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 4, and
329.25 completed according to the requirements of section 245G.05. A county is an eligible vendor
329.26 of care coordination services when provided by an individual who meets the staffing
329.27 credentials of section 245G.11, subdivisions 1 and 7, and provided according to the
329.28 requirements of section 245G.07, subdivision 1, clause (7).

329.29 (d) On July 1, 2018, or upon federal approval, whichever is later, a recovery community
329.30 organization that meets certification requirements identified by the commissioner is an
329.31 eligible vendor of peer support services.

329.32 (e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
329.33 9530.6590, are not eligible vendors. Programs that are not licensed as a ~~chemical dependency~~

330.1 residential or nonresidential substance use disorder treatment or withdrawal management
 330.2 program by the commissioner or by tribal government or do not meet the requirements of
 330.3 subdivisions 1a and 1b are not eligible vendors.

330.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

330.5 Sec. 59. Minnesota Statutes 2016, section 254B.05, subdivision 1a, is amended to read:

330.6 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
 330.7 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

330.8 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
 330.9 while residing in the facility and provide consequences for infractions of those rules;

330.10 (2) is determined to meet applicable health and safety requirements;

330.11 (3) is not a jail or prison;

330.12 (4) is not concurrently receiving funds under chapter 256I for the recipient;

330.13 (5) admits individuals who are 18 years of age or older;

330.14 (6) is registered as a board and lodging or lodging establishment according to section
 330.15 157.17;

330.16 (7) has awake staff on site 24 hours per day;

330.17 (8) has staff who are at least 18 years of age and meet the requirements of ~~Minnesota~~

330.18 ~~Rules, part 9530.6450, subpart 1, item A~~ section 245G.11, subdivision 1, paragraph (a);

330.19 (9) has emergency behavioral procedures that meet the requirements of ~~Minnesota Rules,~~

330.20 ~~part 9530.6475~~ section 245G.16;

330.21 (10) meets the requirements of ~~Minnesota Rules, part 9530.6435, subparts 3 and 4, items~~

330.22 ~~A and B~~ section 245G.08, subdivision 5, if administering medications to clients;

330.23 (11) meets the abuse prevention requirements of section 245A.65, including a policy on

330.24 fraternization and the mandatory reporting requirements of section 626.557;

330.25 (12) documents coordination with the treatment provider to ensure compliance with

330.26 section 254B.03, subdivision 2;

330.27 (13) protects client funds and ensures freedom from exploitation by meeting the

330.28 provisions of section 245A.04, subdivision 13;

330.29 (14) has a grievance procedure that meets the requirements of ~~Minnesota Rules, part~~

330.30 ~~9530.6470, subpart 2~~ section 245G.15, subdivision 2; and

331.1 (15) has sleeping and bathroom facilities for men and women separated by a door that
331.2 is locked, has an alarm, or is supervised by awake staff.

331.3 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
331.4 paragraph (a), clauses (5) to (15).

331.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

331.6 Sec. 60. Minnesota Statutes 2016, section 254B.05, subdivision 5, is amended to read:

331.7 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for ~~chemical~~
331.8 ~~dependency~~ substance use disorder services and service enhancements funded under this
331.9 chapter.

331.10 (b) Eligible ~~chemical-dependency~~ substance use disorder treatment services include:

331.11 (1) outpatient treatment services that are licensed according to ~~Minnesota Rules, parts~~
331.12 ~~9530.6405 to 9530.6480~~ sections 245G.01 to 245G.17, or applicable tribal license;

331.13 (2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive
331.14 assessments provided according to sections 245.4863, paragraph (a), and 245G.05, and
331.15 Minnesota Rules, part 9530.6422;

331.16 (3) on July 1, 2018, or upon federal approval, whichever is later, care coordination
331.17 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

331.18 (4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
331.19 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

331.20 (5) on July 1, 2018, or upon federal approval, whichever is later, withdrawal management
331.21 services provided according to chapter 245F;

331.22 ~~(2)~~ (6) medication-assisted therapy services that are licensed according to ~~Minnesota~~
331.23 ~~Rules, parts 9530.6405 to 9530.6480 and 9530.6500~~ section 245G.07, subdivision 1, or
331.24 applicable tribal license;

331.25 ~~(3)~~ (7) medication-assisted therapy plus enhanced treatment services that meet the
331.26 requirements of clause ~~(2)~~ (6) and provide nine hours of clinical services each week;

331.27 ~~(4)~~ (8) high, medium, and low intensity residential treatment services that are licensed
331.28 according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505~~, sections
331.29 245G.01 to 245G.17 and 245G.22 or applicable tribal license which provide, respectively,
331.30 30, 15, and five hours of clinical services each week;

332.1 ~~(5)~~ (9) hospital-based treatment services that are licensed according to ~~Minnesota Rules,~~
 332.2 ~~parts 9530.6405 to 9530.6480,~~ sections 245G.01 to 245G.17 or applicable tribal license and
 332.3 licensed as a hospital under sections 144.50 to 144.56;

332.4 ~~(6)~~ (10) adolescent treatment programs that are licensed as outpatient treatment programs
 332.5 according to ~~Minnesota Rules, parts 9530.6405 to 9530.6485,~~ sections 245G.01 to 245G.18
 332.6 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to
 332.7 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

332.8 ~~(7)~~ (11) high-intensity residential treatment services that are licensed according to
 332.9 ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections 245G.01 to 245G.17
 332.10 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each
 332.11 week provided by a state-operated vendor or to clients who have been civilly committed to
 332.12 the commissioner, present the most complex and difficult care needs, and are a potential
 332.13 threat to the community; and

332.14 ~~(8)~~ (12) room and board facilities that meet the requirements of subdivision 1a.

332.15 (c) The commissioner shall establish higher rates for programs that meet the requirements
 332.16 of paragraph (b) and one of the following additional requirements:

332.17 (1) programs that serve parents with their children if the program:

332.18 (i) provides on-site child care during the hours of treatment activity that:

332.19 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
 332.20 9503; or

332.21 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
 332.22 (a), clause (6), and meets the requirements under ~~Minnesota Rules, part 9530.6490, subpart~~
 332.23 4 section 245G.19, subdivision 4; or

332.24 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
 332.25 licensed under chapter 245A as:

332.26 (A) a child care center under Minnesota Rules, chapter 9503; or

332.27 (B) a family child care home under Minnesota Rules, chapter 9502;

332.28 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
 332.29 programs or subprograms serving special populations, if the program or subprogram meets
 332.30 the following requirements:

332.31 (i) is designed to address the unique needs of individuals who share a common language,
 332.32 racial, ethnic, or social background;

- 333.1 (ii) is governed with significant input from individuals of that specific background; and
- 333.2 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
333.3 whom are of that specific background, except when the common social background of the
333.4 individuals served is a traumatic brain injury or cognitive disability and the program employs
333.5 treatment staff who have the necessary professional training, as approved by the
333.6 commissioner, to serve clients with the specific disabilities that the program is designed to
333.7 serve;
- 333.8 (3) programs that offer medical services delivered by appropriately credentialed health
333.9 care staff in an amount equal to two hours per client per week if the medical needs of the
333.10 client and the nature and provision of any medical services provided are documented in the
333.11 client file; and
- 333.12 (4) programs that offer services to individuals with co-occurring mental health and
333.13 chemical dependency problems if:
- 333.14 (i) the program meets the co-occurring requirements in ~~Minnesota Rules, part 9530.6495~~
333.15 section 245G.20;
- 333.16 (ii) 25 percent of the counseling staff are licensed mental health professionals, as defined
333.17 in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates
333.18 under the supervision of a licensed alcohol and drug counselor supervisor and licensed
333.19 mental health professional, except that no more than 50 percent of the mental health staff
333.20 may be students or licensing candidates with time documented to be directly related to
333.21 provisions of co-occurring services;
- 333.22 (iii) clients scoring positive on a standardized mental health screen receive a mental
333.23 health diagnostic assessment within ten days of admission;
- 333.24 (iv) the program has standards for multidisciplinary case review that include a monthly
333.25 review for each client that, at a minimum, includes a licensed mental health professional
333.26 and licensed alcohol and drug counselor, and their involvement in the review is documented;
- 333.27 (v) family education is offered that addresses mental health and substance abuse disorders
333.28 and the interaction between the two; and
- 333.29 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
333.30 training annually.
- 333.31 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
333.32 that provides arrangements for off-site child care must maintain current documentation at
333.33 the chemical dependency facility of the child care provider's current licensure to provide

334.1 child care services. Programs that provide child care according to paragraph (c), clause (1),
 334.2 must be deemed in compliance with the licensing requirements in ~~Minnesota Rules, part~~
 334.3 ~~9530.6490~~ section 245G.19.

334.4 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
 334.5 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
 334.6 in paragraph (c), clause (4), items (i) to (iv).

334.7 (f) Subject to federal approval, chemical dependency services that are otherwise covered
 334.8 as direct face-to-face services may be provided via two-way interactive video. The use of
 334.9 two-way interactive video must be medically appropriate to the condition and needs of the
 334.10 person being served. Reimbursement shall be at the same rates and under the same conditions
 334.11 that would otherwise apply to direct face-to-face services. The interactive video equipment
 334.12 and connection must comply with Medicare standards in effect at the time the service is
 334.13 provided.

334.14 **EFFECTIVE DATE.** This section is effective January 1, 2018.

334.15 Sec. 61. Minnesota Statutes 2016, section 254B.051, is amended to read:

334.16 **254B.051 SUBSTANCE ~~ABUSE~~ USE DISORDER TREATMENT**
 334.17 **EFFECTIVENESS.**

334.18 In addition to the substance ~~abuse~~ use disorder treatment program performance outcome
 334.19 measures that the commissioner of human services collects annually from treatment providers,
 334.20 the commissioner shall request additional data from programs that receive appropriations
 334.21 from the consolidated chemical dependency treatment fund. This data shall include number
 334.22 of client readmissions six months after release from inpatient treatment, and the cost of
 334.23 treatment per person for each program receiving consolidated chemical dependency treatment
 334.24 funds. The commissioner may post this data on the department Web site.

334.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

334.26 Sec. 62. Minnesota Statutes 2016, section 254B.07, is amended to read:

334.27 **254B.07 THIRD-PARTY LIABILITY.**

334.28 The state agency provision and payment of, or liability for, ~~chemical dependency~~
 334.29 substance use disorder medical care is the same as in section 256B.042.

334.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

335.1 Sec. 63. Minnesota Statutes 2016, section 254B.08, is amended to read:

335.2 **254B.08 FEDERAL WAIVERS.**

335.3 The commissioner shall apply for any federal waivers necessary to secure, to the extent
335.4 allowed by law, federal financial participation for the provision of services to persons who
335.5 need ~~chemical dependency~~ substance use disorder services. The commissioner may seek
335.6 amendments to the waivers or apply for additional waivers to contain costs. The
335.7 commissioner shall ensure that payment for the cost of providing ~~chemical dependency~~
335.8 substance use disorder services under the federal waiver plan does not exceed the cost of
335.9 ~~chemical dependency~~ substance use disorder services that would have been provided without
335.10 the waived services.

335.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

335.12 Sec. 64. Minnesota Statutes 2016, section 254B.09, is amended to read:

335.13 **254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL**
335.14 **DEPENDENCY FUND.**

335.15 Subdivision 1. **Vendor payments.** The commissioner shall pay eligible vendors for
335.16 ~~chemical dependency~~ substance use disorder services to American Indians on the same
335.17 basis as other payments, except that no local match is required when an invoice is submitted
335.18 by the governing authority of a federally recognized American Indian tribal body or a county
335.19 if the tribal governing body has not entered into an agreement under subdivision 2 on behalf
335.20 of a current resident of the reservation under this section.

335.21 Subd. 2. **American Indian agreements.** The commissioner may enter into agreements
335.22 with federally recognized tribal units to pay for ~~chemical dependency~~ substance use disorder
335.23 treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements
335.24 must clarify how the governing body of the tribal unit fulfills local agency responsibilities
335.25 regarding:

335.26 (1) the form and manner of invoicing; and

335.27 (2) provide that only invoices for eligible vendors according to section 254B.05 will be
335.28 included in invoices sent to the commissioner for payment, to the extent that money allocated
335.29 under subdivisions 4 and 5 is used.

335.30 Subd. 6. **American Indian tribal placements.** After entering into an agreement under
335.31 subdivision 2, the governing authority of each reservation may submit invoices to the state
335.32 for the cost of providing ~~chemical dependency~~ substance use disorder services to residents

336.1 of the reservation according to the placement rules governing county placements, except
336.2 that local match requirements are waived. The governing body may designate an agency to
336.3 act on its behalf to provide placement services and manage invoices by written notice to
336.4 the commissioner and evidence of agreement by the agency designated.

336.5 Subd. 8. **Payments to improve services to American Indians.** The commissioner may
336.6 set rates for ~~chemical dependency~~ substance use disorder services to American Indians
336.7 according to the American Indian Health Improvement Act, Public Law 94-437, for eligible
336.8 vendors. These rates shall supersede rates set in county purchase of service agreements
336.9 when payments are made on behalf of clients eligible according to Public Law 94-437.

336.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

336.11 Sec. 65. Minnesota Statutes 2016, section 254B.12, subdivision 2, is amended to read:

336.12 Subd. 2. **Payment methodology for highly specialized vendors.** Notwithstanding
336.13 subdivision 1, the commissioner shall seek federal authority to develop separate payment
336.14 methodologies for ~~chemical dependency~~ substance use disorder treatment services provided
336.15 under the consolidated chemical dependency treatment fund: (1) by a state-operated vendor;
336.16 or (2) for persons who have been civilly committed to the commissioner, present the most
336.17 complex and difficult care needs, and are a potential threat to the community. A payment
336.18 methodology under this subdivision is effective for services provided on or after October
336.19 1, 2015, or on or after the receipt of federal approval, whichever is later.

336.20 **EFFECTIVE DATE.** This section is effective January 1, 2018.

336.21 Sec. 66. Minnesota Statutes 2016, section 254B.12, is amended by adding a subdivision
336.22 to read:

336.23 Subd. 3. **Chemical dependency provider rate increase.** For the chemical dependency
336.24 services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2017,
336.25 payment rates shall be increased by one percent over the rates in effect on January 1, 2017,
336.26 for vendors who meet the requirements of section 254B.05.

336.27 Sec. 67. Minnesota Statutes 2016, section 254B.13, subdivision 2a, is amended to read:

336.28 Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation
336.29 in a navigator pilot program, an individual must:

336.30 (1) be a resident of a county with an approved navigator program;

336.31 (2) be eligible for consolidated chemical dependency treatment fund services;

337.1 (3) be a voluntary participant in the navigator program;

337.2 (4) satisfy one of the following items:

337.3 (i) have at least one severity rating of three or above in dimension four, five, or six in a
337.4 comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~ section 245G.05,
337.5 paragraph (c), clauses (4) to (6); or

337.6 (ii) have at least one severity rating of two or above in dimension four, five, or six in a
337.7 comprehensive assessment under ~~Minnesota Rules, part 9530.6422,~~ section 245G.05,
337.8 paragraph (c), clauses (4) to (6), and be currently participating in a Rule 31 treatment program
337.9 under ~~Minnesota Rules, parts 9530.6405 to 9530.6505,~~ chapter 245G or be within 60 days
337.10 following discharge after participation in a Rule 31 treatment program; and

337.11 (5) have had at least two treatment episodes in the past two years, not limited to episodes
337.12 reimbursed by the consolidated chemical dependency treatment funds. An admission to an
337.13 emergency room, a detoxification program, or a hospital may be substituted for one treatment
337.14 episode if it resulted from the individual's substance use disorder.

337.15 (b) New eligibility criteria may be added as mutually agreed upon by the commissioner
337.16 and participating navigator programs.

337.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

337.18 Sec. 68. Minnesota Statutes 2016, section 256B.0625, subdivision 45a, is amended to
337.19 read:

337.20 Subd. 45a. **Psychiatric residential treatment facility services for persons under 21**
337.21 **years of age.** (a) Medical assistance covers psychiatric residential treatment facility services,
337.22 according to section 256B.0941, for persons ~~under~~ younger than 21 years of age. Individuals
337.23 who reach age 21 at the time they are receiving services are eligible to continue receiving
337.24 services until they no longer require services or until they reach age 22, whichever occurs
337.25 first.

337.26 (b) For purposes of this subdivision, "psychiatric residential treatment facility" means
337.27 a facility other than a hospital that provides psychiatric services, as described in Code of
337.28 Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in
337.29 an inpatient setting.

337.30 (c) ~~The commissioner shall develop admissions and discharge procedures and establish~~
337.31 ~~rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.~~

338.1 ~~(d)~~ The commissioner shall enroll up to 150 certified psychiatric residential treatment
338.2 facility services beds at up to six sites. The commissioner shall select psychiatric residential
338.3 treatment facility services providers through a request for proposals process. Providers of
338.4 state-operated services may respond to the request for proposals.

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

338.6 Sec. 69. **[256B.0941] PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY**
338.7 **FOR PERSONS UNDER 21 YEARS OF AGE.**

338.8 Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment
338.9 services in a psychiatric residential treatment facility must meet all of the following criteria:

338.10 (1) before admission, services are determined to be medically necessary by the state's
338.11 medical review agent according to Code of Federal Regulations, title 42, section 441.152;

338.12 (2) is younger than 21 years of age at the time of admission. Services may continue until
338.13 the individual meets criteria for discharge or reaches 22 years of age, whichever occurs
338.14 first;

338.15 (3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic
338.16 and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression,
338.17 or a finding that the individual is a risk to self or others;

338.18 (4) has functional impairment and a history of difficulty in functioning safely and
338.19 successfully in the community, school, home, or job; an inability to adequately care for
338.20 one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill
338.21 the individual's needs;

338.22 (5) requires psychiatric residential treatment under the direction of a physician to improve
338.23 the individual's condition or prevent further regression so that services will no longer be
338.24 needed;

338.25 (6) utilized and exhausted other community-based mental health services, or clinical
338.26 evidence indicates that such services cannot provide the level of care needed; and

338.27 (7) was referred for treatment in a psychiatric residential treatment facility by a qualified
338.28 mental health professional licensed as defined in section 245.4871, subdivision 27, clauses
338.29 (1) to (6).

338.30 (b) A mental health professional making a referral shall submit documentation to the
338.31 state's medical review agent containing all information necessary to determine medical
338.32 necessity, including a standard diagnostic assessment completed within 180 days of the

339.1 individual's admission. Documentation shall include evidence of family participation in the
339.2 individual's treatment planning and signed consent for services.

339.3 Subd. 2. **Services.** Psychiatric residential treatment facility service providers must offer
339.4 and have the capacity to provide the following services:

339.5 (1) development of the individual plan of care, review of the individual plan of care
339.6 every 30 days, and discharge planning by required members of the treatment team according
339.7 to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

339.8 (2) any services provided by a psychiatrist or physician for development of an individual
339.9 plan of care, conducting a review of the individual plan of care every 30 days, and discharge
339.10 planning by required members of the treatment team according to Code of Federal
339.11 Regulations, title 42, sections 441.155 to 441.156;

339.12 (3) active treatment seven days per week that may include individual, family, or group
339.13 therapy as determined by the individual care plan;

339.14 (4) individual therapy, provided a minimum of twice per week;

339.15 (5) family engagement activities, provided a minimum of once per week;

339.16 (6) consultation with other professionals, including case managers, primary care
339.17 professionals, community-based mental health providers, school staff, or other support
339.18 planners;

339.19 (7) coordination of educational services between local and resident school districts and
339.20 the facility;

339.21 (8) 24-hour nursing; and

339.22 (9) direct care and supervision, supportive services for daily living and safety, and
339.23 positive behavior management.

339.24 Subd. 3. **Per diem rate.** (a) The commissioner shall establish a statewide per diem rate
339.25 for psychiatric residential treatment facility services for individuals 21 years of age or
339.26 younger. The rate for a provider must not exceed the rate charged by that provider for the
339.27 same service to other payers. Payment must not be made to more than one entity for each
339.28 individual for services provided under this section on a given day. The commissioner shall
339.29 set rates prospectively for the annual rate period. The commissioner shall require providers
339.30 to submit annual cost reports on a uniform cost reporting form and shall use submitted cost
339.31 reports to inform the rate-setting process. The cost reporting shall be done according to
339.32 federal requirements for Medicare cost reports.

340.1 (b) The following are included in the rate:

340.2 (1) costs necessary for licensure and accreditation, meeting all staffing standards for
340.3 participation, meeting all service standards for participation, meeting all requirements for
340.4 active treatment, maintaining medical records, conducting utilization review, meeting
340.5 inspection of care, and discharge planning. The direct services costs must be determined
340.6 using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff
340.7 and service-related transportation; and

340.8 (2) payment for room and board provided by facilities meeting all accreditation and
340.9 licensing requirements for participation.

340.10 (c) A facility may submit a claim for payment outside of the per diem for professional
340.11 services arranged by and provided at the facility by an appropriately licensed professional
340.12 who is enrolled as a provider with Minnesota health care programs. Arranged services must
340.13 be billed by the facility on a separate claim, and the facility shall be responsible for payment
340.14 to the provider. These services must be included in the individual plan of care and are subject
340.15 to prior authorization by the state's medical review agent.

340.16 (d) Medicaid shall reimburse for concurrent services as approved by the commissioner
340.17 to support continuity of care and successful discharge from the facility. "Concurrent services"
340.18 means services provided by another entity or provider while the individual is admitted to a
340.19 psychiatric residential treatment facility. Payment for concurrent services may be limited
340.20 and these services are subject to prior authorization by the state's medical review agent.
340.21 Concurrent services may include targeted case management, assertive community treatment,
340.22 clinical care consultation, team consultation, and treatment planning.

340.23 (e) Payment rates under this subdivision shall not include the costs of providing the
340.24 following services:

340.25 (1) educational services;

340.26 (2) acute medical care or specialty services for other medical conditions;

340.27 (3) dental services; and

340.28 (4) pharmacy drug costs.

340.29 (f) For purposes of this section, "actual cost" means costs that are allowable, allocable,
340.30 reasonable, and consistent with federal reimbursement requirements in Code of Federal
340.31 Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of
340.32 Management and Budget Circular Number A-122, relating to nonprofit entities.

341.1 Subd. 4. **Leave days.** (a) Medical assistance covers therapeutic and hospital leave days,
341.2 provided the recipient was not discharged from the psychiatric residential treatment facility
341.3 and is expected to return to the psychiatric residential treatment facility. A reserved bed
341.4 must be held for a recipient on hospital leave or therapeutic leave.

341.5 (b) A therapeutic leave day to home shall be used to prepare for discharge and
341.6 reintegration and shall be included in the individual plan of care. The state shall reimburse
341.7 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic
341.8 leave. A therapeutic leave visit may not exceed three days without prior authorization.

341.9 (c) A hospital leave day shall be a day for which a recipient has been admitted to a
341.10 hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric
341.11 residential treatment facility. The state shall reimburse 50 percent of the per diem rate for
341.12 a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

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

341.14 Sec. 70. Minnesota Statutes 2016, section 256B.0943, subdivision 13, is amended to read:

341.15 Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15
341.16 hours of children's therapeutic services and supports provided within a six-month period to
341.17 a child with severe emotional disturbance who is residing in a hospital; ~~a group home as~~
341.18 ~~defined in Minnesota Rules, parts 2960.0130 to 2960.0220;~~ a residential treatment facility
341.19 licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential
341.20 treatment facility under section 256B.0625, subdivision 45a; a regional treatment center;
341.21 or other institutional group setting or who is participating in a program of partial
341.22 hospitalization are eligible for medical assistance payment if part of the discharge plan.

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

341.24 Sec. 71. Minnesota Statutes 2016, section 256B.0945, subdivision 2, is amended to read:

341.25 Subd. 2. **Covered services.** All services must be included in a child's individualized
341.26 treatment or multiagency plan of care as defined in chapter 245.

341.27 For facilities that are not institutions for mental diseases according to federal statute and
341.28 regulation, medical assistance covers mental health-related services that are required to be
341.29 provided by a residential facility under section 245.4882 and administrative rules promulgated
341.30 thereunder, except for room and board. For residential facilities determined by the federal
341.31 Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical

342.1 assistance covers medically necessary mental health services provided by the facility
342.2 according to section 256B.055, subdivision 13, except for room and board.

342.3 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
342.4 through April 30, 2019, and expires May 1, 2019.

342.5 Sec. 72. Minnesota Statutes 2016, section 256B.0945, subdivision 4, is amended to read:

342.6 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments
342.7 to counties for residential services provided under this section by a residential facility shall:

342.8 (1) for services provided by a residential facility that is not an institution for mental
342.9 diseases, only be made of federal earnings for services provided ~~under this section~~, and the
342.10 nonfederal share of costs for services provided under this section shall be paid by the county
342.11 from sources other than federal funds or funds used to match other federal funds. Payment
342.12 to counties for services provided according to this section shall be a proportion of the per
342.13 day contract rate that relates to rehabilitative mental health services and shall not include
342.14 payment for costs or services that are billed to the IV-E program as room and board-; and

342.15 (2) for services provided by a residential facility that is determined to be an institution
342.16 for mental diseases, be equivalent to the federal share of the payment that would have been
342.17 made if the residential facility were not an institution for mental diseases. The portion of
342.18 the payment representing what would be the nonfederal shares shall be paid by the county.
342.19 Payment to counties for services provided according to this section shall be a proportion of
342.20 the per day contract rate that relates to rehabilitative mental health services and shall not
342.21 include payment for costs or services that are billed to the IV-E program as room and board.

342.22 (b) Per diem rates paid to providers under this section by prepaid plans shall be the
342.23 proportion of the per-day contract rate that relates to rehabilitative mental health services
342.24 and shall not include payment for group foster care costs or services that are billed to the
342.25 county of financial responsibility. Services provided in facilities located in bordering states
342.26 are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a)
342.27 and are not covered under prepaid health plans.

342.28 (c) Payment for mental health rehabilitative services provided under this section by or
342.29 under contract with an American Indian tribe or tribal organization or by agencies operated
342.30 by or under contract with an American Indian tribe or tribal organization must be made
342.31 according to section 256B.0625, subdivision 34, or other relevant federally approved
342.32 rate-setting methodology.

343.1 (d) The commissioner shall set aside a portion not to exceed five percent of the federal
343.2 funds earned for county expenditures under this section to cover the state costs of
343.3 administering this section. Any unexpended funds from the set-aside shall be distributed to
343.4 the counties in proportion to their earnings under this section.

343.5 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
343.6 through April 30, 2019, and expires May 1, 2019.

343.7 Sec. 73. Minnesota Statutes 2016, section 256B.763, is amended to read:

343.8 **256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

343.9 (a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment
343.10 rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

343.11 (1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

343.12 (2) community mental health centers under section 256B.0625, subdivision 5; and

343.13 (3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750
343.14 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential
343.15 community providers under section 62Q.19.

343.16 (b) This increase applies to group skills training when provided as a component of
343.17 children's therapeutic services and support, psychotherapy, medication management,
343.18 evaluation and management, diagnostic assessment, explanation of findings, psychological
343.19 testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

343.20 (c) This increase does not apply to rates that are governed by section 256B.0625,
343.21 subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated
343.22 with the county, rates that are established by the federal government, or rates that increased
343.23 between January 1, 2004, and January 1, 2005.

343.24 (d) The commissioner shall adjust rates paid to prepaid health plans under contract with
343.25 the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The
343.26 prepaid health plan must pass this rate increase to the providers identified in paragraphs (a),
343.27 (e), (f), and (g).

343.28 (e) Payment rates shall be increased by 23.7 percent over the rates in effect on December
343.29 31, 2007, for:

343.30 (1) medication education services provided on or after January 1, 2008, by adult
343.31 rehabilitative mental health services providers certified under section 256B.0623; and

344.1 (2) mental health behavioral aide services provided on or after January 1, 2008, by
344.2 children's therapeutic services and support providers certified under section 256B.0943.

344.3 (f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by
344.4 children's therapeutic services and support providers certified under section 256B.0943 and
344.5 not already included in paragraph (a), payment rates shall be increased by 23.7 percent over
344.6 the rates in effect on December 31, 2007.

344.7 (g) Payment rates shall be increased by 2.3 percent over the rates in effect on December
344.8 31, 2007, for individual and family skills training provided on or after January 1, 2008, by
344.9 children's therapeutic services and support providers certified under section 256B.0943.

344.10 (h) For services described in paragraphs (b), (e), and (g) and rendered on or after July
344.11 1, 2017, payment rates for mental health clinics and centers certified under Minnesota Rules,
344.12 parts 9520.0750 to 9520.0870, that are not designated as essential community providers
344.13 under section 62Q.19 shall be equal to payment rates for mental health clinics and centers
344.14 certified under Minnesota Rules, parts 9520.0750 to 9520.0870, that are designated as
344.15 essential community providers under section 62Q.19. In order to receive increased payment
344.16 rates under this paragraph, a provider must demonstrate a commitment to serve low-income
344.17 and underserved populations by:

344.18 (1) charging for services on a sliding-fee schedule based on current poverty income
344.19 guidelines; and

344.20 (2) not restricting access or services because of a client's financial limitation.

344.21 **Sec. 74. CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

344.22 The commissioner of human services shall conduct a comprehensive analysis of
344.23 Minnesota's continuum of intensive mental health services and shall develop
344.24 recommendations for a sustainable and community-driven continuum of care for children
344.25 with serious mental health needs, including children currently being served in residential
344.26 treatment. The commissioner's analysis shall include, but not be limited to:

344.27 (1) data related to access, utilization, efficacy, and outcomes for Minnesota's current
344.28 system of residential mental health treatment for a child with a severe emotional disturbance;

344.29 (2) potential expansion of the state's psychiatric residential treatment facility (PRTF)
344.30 capacity, including increasing the number of PRTF beds and conversion of existing children's
344.31 mental health residential treatment programs into PRTFs;

345.1 (3) the capacity need for PRTF and other group settings within the state if adequate
345.2 community-based alternatives are accessible, equitable, and effective statewide;

345.3 (4) recommendations for expanding alternative community-based service models to
345.4 meet the needs of a child with a serious mental health disorder who would otherwise require
345.5 residential treatment and potential service models that could be utilized, including data
345.6 related to access, utilization, efficacy, and outcomes;

345.7 (5) models of care used in other states; and

345.8 (6) analysis and specific recommendations for the design and implementation of new
345.9 service models, including analysis to inform rate setting as necessary.

345.10 The analysis shall be supported and informed by extensive stakeholder engagement.

345.11 Stakeholders include individuals who receive services, family members of individuals who
345.12 receive services, providers, counties, health plans, advocates, and others. Stakeholder
345.13 engagement shall include interviews with key stakeholders, intentional outreach to individuals
345.14 who receive services and the individual's family members, and regional listening sessions.

345.15 The commissioner shall provide a report with specific recommendations and timelines
345.16 for implementation to the legislative committees with jurisdiction over children's mental
345.17 health policy and finance by November 15, 2018.

345.18 **Sec. 75. RESIDENTIAL TREATMENT AND PAYMENT RATE REFORM.**

345.19 The commissioner shall contract with an outside expert to identify recommendations
345.20 for the development of a substance use disorder residential treatment program model and
345.21 payment structure that is not subject to the federal institutions for mental diseases exclusion
345.22 and that is financially sustainable for providers, while incentivizing best practices and
345.23 improved treatment outcomes. The analysis must include recommendations and a timeline
345.24 for supporting providers to transition to the new models of care delivery. No later than
345.25 December 15, 2018, the commissioner shall deliver a report with recommendations to the
345.26 chairs and ranking minority members of the legislative committees with jurisdiction over
345.27 health and human services policy and finance.

345.28 **Sec. 76. REVISOR'S INSTRUCTION.**

345.29 In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with
345.30 the with the Department of Human Services, shall make necessary cross-reference changes
345.31 that are needed as a result of the enactment of sections 12 to 35 and 75. The revisor shall
345.32 make any necessary technical and grammatical changes to preserve the meaning of the text.

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

346.2 Sec. 77. **REPEALER.**

346.3 (a) Minnesota Statutes 2016, sections 245A.1915; 245A.192; and 254A.02, subdivision
346.4 4, are repealed.

346.5 (b) Minnesota Rules, parts 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11,
346.6 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, and 21; 9530.6410; 9530.6415;
346.7 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445;
346.8 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480;
346.9 9530.6485; 9530.6490; 9530.6495; 9530.6500; and 9530.6505, are repealed.

346.10 (c) Minnesota Statutes 2016, section 256B.7631, is repealed.

346.11 **EFFECTIVE DATE.** Paragraphs (a) and (b) are effective January 1, 2018. Paragraph
346.12 (c) is effective the day following final enactment.

346.13

ARTICLE 9

346.14

OPERATIONS

346.15 Section 1. Minnesota Statutes 2016, section 245A.02, subdivision 2b, is amended to read:

346.16 Subd. 2b. **Annual or annually.** With the exception of subdivision 2c, "annual" or
346.17 "annually" means prior to or within the same month of the subsequent calendar year.

346.18 Sec. 2. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to
346.19 read:

346.20 Subd. 2c. **Annual or annually; family child care training requirements.** For the
346.21 purposes of section 245A.50, subdivisions 1 to 9, "annual" or "annually" means the 12-month
346.22 period beginning on the license effective date or the annual anniversary of the effective date
346.23 and ending on the day prior to the annual anniversary of the license effective date.

346.24 Sec. 3. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

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

346.28 (1) an inspection of the physical plant;

346.29 (2) an inspection of records and documents;

347.1 (3) an evaluation of the program by consumers of the program; and

347.2 (4) observation of the program in operation.

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

347.6 (b) The evaluation required in paragraph (a), clause (3),² or the observation in paragraph
347.7 (a), clause (4),² is not required prior to issuing an initial license under subdivision 7. If the
347.8 commissioner issues an initial license under subdivision 7, these requirements must be
347.9 completed within one year after the issuance of an initial license.

347.10 (c) Before completing a licensing inspection in a family child care program or child care
347.11 center, the licensing agency must offer the license holder an exit interview to discuss
347.12 violations of law or rule observed during the inspection and offer technical assistance on
347.13 how to comply with applicable laws and rules. Nothing in this paragraph limits the ability
347.14 of the commissioner to issue a correction order or negative action for violations of law or
347.15 rule not discussed in an exit interview or in the event that a license holder chooses not to
347.16 participate in an exit interview.

347.17 **EFFECTIVE DATE.** This section is effective October 1, 2017.

347.18 Sec. 4. Minnesota Statutes 2016, section 245A.06, subdivision 2, is amended to read:

347.19 Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder
347.20 believes that the contents of the commissioner's correction order are in error, the applicant
347.21 or license holder may ask the Department of Human Services to reconsider the parts of the
347.22 correction order that are alleged to be in error. The request for reconsideration must be made
347.23 in writing and must be postmarked and sent to the commissioner within 20 calendar days
347.24 after receipt of the correction order by the applicant or license holder, and:

347.25 (1) specify the parts of the correction order that are alleged to be in error;

347.26 (2) explain why they are in error; and

347.27 (3) include documentation to support the allegation of error.

347.28 A request for reconsideration does not stay any provisions or requirements of the
347.29 correction order. The commissioner's disposition of a request for reconsideration is final
347.30 and not subject to appeal under chapter 14.

347.31 (b) This paragraph applies only to licensed family child care providers. A licensed family
347.32 child care provider who requests reconsideration of a correction order under paragraph (a)

348.1 may also request, on a form and in the manner prescribed by the commissioner, that the
348.2 commissioner expedite the review if:

348.3 (1) the provider is challenging a violation and provides a description of how complying
348.4 with the corrective action for that violation would require the substantial expenditure of
348.5 funds or a significant change to their program; and

348.6 (2) describes what actions the provider will take in lieu of the corrective action ordered
348.7 to ensure the health and safety of children in care pending the commissioner's review of the
348.8 correction order.

348.9 Sec. 5. Minnesota Statutes 2016, section 245A.06, subdivision 8, is amended to read:

348.10 Subd. 8. **Requirement to post correction order.** (a) For licensed family child care
348.11 providers and child care centers, upon receipt of any correction order or order of conditional
348.12 license issued by the commissioner under this section, and notwithstanding a pending request
348.13 for reconsideration of the correction order or order of conditional license by the license
348.14 holder, the license holder shall post the correction order or order of conditional license in
348.15 a place that is conspicuous to the people receiving services and all visitors to the facility
348.16 for two years. When the correction order or order of conditional license is accompanied by
348.17 a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the
348.18 investigation memoranda must be posted with the correction order or order of conditional
348.19 license.

348.20 (b) If the commissioner reverses or rescinds a violation in a correction order upon
348.21 reconsideration under subdivision 2, the commissioner shall issue an amended correction
348.22 order and the license holder shall post the amended order according to paragraph (a).

348.23 (c) If the correction order is rescinded or reversed in full upon reconsideration under
348.24 subdivision 2, the license holder shall remove the original correction order posted according
348.25 to paragraph (a).

348.26 Sec. 6. Minnesota Statutes 2016, section 245A.06, is amended by adding a subdivision to
348.27 read:

348.28 Subd. 9. **Child care correction order quotas prohibited.** The commissioner and county
348.29 licensing agencies shall not order, mandate, require, or suggest to any person responsible
348.30 for licensing or inspecting a licensed family child care provider or child care center a quota
348.31 for the issuance of correction orders on a daily, weekly, monthly, quarterly, or yearly basis.

349.1 **Sec. 7. [245A.065] CHILD CARE FIX-IT TICKET.**

349.2 (a) In lieu of a correction order under section 245A.06, the commissioner shall issue a
349.3 fix-it ticket to a family child care or child care center license holder if the commissioner
349.4 finds that:

349.5 (1) the license holder has failed to comply with a requirement in this chapter or Minnesota
349.6 Rules, chapter 9502 or 9503, that the commissioner determines to be eligible for a fix-it
349.7 ticket;

349.8 (2) the violation does not imminently endanger the health, safety, or rights of the persons
349.9 served by the program;

349.10 (3) the license holder did not receive a fix-it ticket or correction order for the violation
349.11 at the license holder's last licensing inspection;

349.12 (4) the violation can be corrected at the time of inspection or within 48 hours, excluding
349.13 Saturdays, Sundays, and holidays; and

349.14 (5) the license holder corrects the violation at the time of inspection or agrees to correct
349.15 the violation within 48 hours, excluding Saturdays, Sundays, and holidays.

349.16 (b) The fix-it ticket must state:

349.17 (1) the conditions that constitute a violation of the law or rule;

349.18 (2) the specific law or rule violated; and

349.19 (3) that the violation was corrected at the time of inspection or must be corrected within
349.20 48 hours, excluding Saturdays, Sundays, and holidays.

349.21 (c) The commissioner shall not publicly publish a fix-it ticket on the department's Web
349.22 site.

349.23 (d) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it
349.24 ticket, the license holder must correct the violation and within one week submit evidence
349.25 to the licensing agency that the violation was corrected.

349.26 (e) If the violation is not corrected at the time of inspection or within 48 hours, excluding
349.27 Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to establish that
349.28 the license holder corrected the violation, the commissioner must issue a correction order
349.29 for the violation of Minnesota law or rule identified in the fix-it ticket according to section
349.30 245A.06.

350.1 (f) The commissioner shall, following consultation with family child care license holders,
350.2 child care center license holders, and county agencies, issue a report by October 1, 2017,
350.3 that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503,
350.4 that are eligible for a fix-it ticket. The commissioner shall provide the report to county
350.5 agencies and the chairs and ranking minority members of the legislative committees with
350.6 jurisdiction over child care, and shall post the report to the department's Web site.

350.7 **EFFECTIVE DATE.** This section is effective October 1, 2017.

350.8 Sec. 8. Minnesota Statutes 2016, section 245A.07, subdivision 3, is amended to read:

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

350.11 (1) a license holder fails to comply fully with applicable laws or rules;

350.12 (2) a license holder, a controlling individual, or an individual living in the household
350.13 where the licensed services are provided or is otherwise subject to a background study has
350.14 a disqualification which has not been set aside under section 245C.22;

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

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

350.22 A license holder who has had a license suspended, revoked, or has been ordered to pay
350.23 a fine must be given notice of the action by certified mail or personal service. If mailed, the
350.24 notice must be mailed to the address shown on the application or the last known address of
350.25 the license holder. The notice must state the reasons the license was suspended, revoked,
350.26 or a fine was ordered.

350.27 (b) If the license was suspended or revoked, the notice must inform the license holder
350.28 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
350.29 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
350.30 a license. The appeal of an order suspending or revoking a license must be made in writing
350.31 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
350.32 the commissioner within ten calendar days after the license holder receives notice that the
350.33 license has been suspended or revoked. If a request is made by personal service, it must be

351.1 received by the commissioner within ten calendar days after the license holder received the
351.2 order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a
351.3 timely appeal of an order suspending or revoking a license, the license holder may continue
351.4 to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and
351.5 (h), until the commissioner issues a final order on the suspension or revocation.

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

351.14 (2) The license holder shall pay the fines assessed on or before the payment date specified.
351.15 If the license holder fails to fully comply with the order, the commissioner may issue a
351.16 second fine or suspend the license until the license holder complies. If the license holder
351.17 receives state funds, the state, county, or municipal agencies or departments responsible for
351.18 administering the funds shall withhold payments and recover any payments made while the
351.19 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine
351.20 until the commissioner issues a final order.

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

351.27 (4) Fines shall be assessed as follows:

351.28 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
351.29 child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557
351.30 for which the license holder is determined responsible for the maltreatment under section
351.31 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

351.32 (ii) if the commissioner determines that a determination of maltreatment for which the
351.33 license holder is responsible is the result of maltreatment that meets the definition of serious

352.1 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
352.2 \$5,000;

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

352.6 (iv) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule
352.7 governing matters of health, safety, or supervision, including but not limited to the provision
352.8 of adequate staff-to-child or adult ratios, and failure to comply with background study
352.9 requirements under chapter 245C; and

352.10 (v) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule
352.11 other than those subject to a \$5,000, \$1,000, or \$200 fine above in items (i) to (iv).

352.12 For purposes of this section, "occurrence" means each violation identified in the
352.13 commissioner's fine order. Fines assessed against a license holder that holds a license to
352.14 provide home and community-based services, as identified in section 245D.03, subdivision
352.15 1, and a community residential setting or day services facility license under chapter 245D
352.16 where the services are provided, may be assessed against both licenses for the same
352.17 occurrence, but the combined amount of the fines shall not exceed the amount specified in
352.18 this clause for that occurrence.

352.19 (5) When a fine has been assessed, the license holder may not avoid payment by closing,
352.20 selling, or otherwise transferring the licensed program to a third party. In such an event, the
352.21 license holder will be personally liable for payment. In the case of a corporation, each
352.22 controlling individual is personally and jointly liable for payment.

352.23 (d) Except for background study violations involving the failure to comply with an order
352.24 to immediately remove an individual or an order to provide continuous, direct supervision,
352.25 the commissioner shall not issue a fine under paragraph (c) relating to a background study
352.26 violation to a license holder who self-corrects a background study violation before the
352.27 commissioner discovers the violation. A license holder who has previously exercised the
352.28 provisions of this paragraph to avoid a fine for a background study violation may not avoid
352.29 a fine for a subsequent background study violation unless at least 365 days have passed
352.30 since the license holder self-corrected the earlier background study violation.

352.31 **EFFECTIVE DATE.** This section is effective August 1, 2017.

353.1 **Sec. 9. [245A.1434] INFORMATION FOR CHILD CARE LICENSE HOLDERS.**

353.2 The commissioner shall inform family child care and child care center license holders
353.3 on a timely basis of changes to state and federal statute, rule, regulation, and policy relating
353.4 to the provision of licensed child care, the child care assistance program under chapter 119B,
353.5 the quality rating and improvement system under section 124D.142, and child care licensing
353.6 functions delegated to counties. Communications under this section shall include information
353.7 to promote license holder compliance with identified changes. Communications under this
353.8 section may be accomplished by electronic means and shall be made available to the public
353.9 online.

353.10 **Sec. 10. [245A.153] REPORT TO LEGISLATURE ON THE STATUS OF CHILD**
353.11 **CARE.**

353.12 Subdivision 1. **Reporting requirements.** Beginning on February 1, 2018, and no later
353.13 than February 1 of each year thereafter, the commissioner of human services shall provide
353.14 a report on the status of child care in Minnesota to the chairs and ranking minority members
353.15 of the legislative committees with jurisdiction over child care.

353.16 Subd. 2. **Contents of report.** (a) The report must include the following:

353.17 (1) summary data on trends in child care center and family child care capacity and
353.18 availability throughout the state, including the number of centers and programs that have
353.19 opened and closed and the geographic locations of those centers and programs;

353.20 (2) a description of any changes to statutes, administrative rules, or agency policies and
353.21 procedures that were implemented in the year preceding the report;

353.22 (3) a description of the actions the department has taken to address or implement the
353.23 recommendations from the Legislative Task Force on Access to Affordable Child Care
353.24 Report dated January 15, 2017, including but not limited to actions taken in the areas of:

353.25 (i) encouraging uniformity in implementing and interpreting statutes, administrative
353.26 rules, and agency policies and procedures relating to child care licensing and access;

353.27 (ii) improving communication with county licensors and child care providers regarding
353.28 changes to statutes, administrative rules, and agency policies and procedures, ensuring that
353.29 information is directly and regularly transmitted;

353.30 (iii) providing notice to child care providers before issuing correction orders or negative
353.31 actions relating to recent changes to statutes, administrative rules, and agency policies and
353.32 procedures;

354.1 (iv) implementing confidential, anonymous communication processes for child care
 354.2 providers to ask questions and receive prompt, clear answers from the department;

354.3 (v) streamlining processes to reduce duplication or overlap in paperwork and training
 354.4 requirements for child care providers; and

354.5 (vi) compiling and distributing information detailing trends in the violations for which
 354.6 correction orders and negative actions are issued;

354.7 (4) a description of the department's efforts to cooperate with counties while addressing
 354.8 and implementing the task force recommendations;

354.9 (5) summary data on child care assistance programs including but not limited to state
 354.10 funding and numbers of families served; and

354.11 (6) summary data on family child care correction orders, including:

354.12 (i) the number of licensed family child care provider appeals or requests for
 354.13 reconsideration of correction orders to the Department of Human Services;

354.14 (ii) the number of family child care correction order appeals or requests for
 354.15 reconsideration that the Department of Human Services grants; and

354.16 (iii) the number of family child care correction order appeals or requests for
 354.17 reconsideration that the Department of Human Services denies.

354.18 (b) The commissioner may offer recommendations for legislative action.

354.19 Subd. 3. **Sunset.** This section expires February 2, 2020.

354.20 Sec. 11. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

354.21 Subd. 3c. **Local welfare agency, Department of Human Services or Department of**
 354.22 **Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~
 354.23 local welfare agency is the agency responsible for assessing or investigating allegations of
 354.24 maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child
 354.25 care, ~~juvenile correctional facilities licensed under section 241.021 located in the local~~
 354.26 ~~welfare agency's county~~, and reports involving children served by an unlicensed personal
 354.27 care provider organization under section 256B.0659. Copies of findings related to personal
 354.28 care provider organizations under section 256B.0659 must be forwarded to the Department
 354.29 of Human Services provider enrollment.

354.30 (b) The Department of Human Services is the agency responsible for assessing or
 354.31 investigating allegations of maltreatment in juvenile correctional facilities listed under

355.1 section 241.021 located in the local welfare agency's county and in facilities licensed or
 355.2 certified under chapters 245A and 245D, except for child foster care and family child care.

355.3 (c) The Department of Health is the agency responsible for assessing or investigating
 355.4 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
 355.5 144A.43 to 144A.482.

355.6 ARTICLE 10

355.7 HEALTH DEPARTMENT

355.8 Section 1. Minnesota Statutes 2016, section 103I.005, subdivision 2, is amended to read:

355.9 Subd. 2. **Boring.** "Boring" means a hole or excavation that is not used to extract water
 355.10 and includes exploratory borings, ~~environmental bore holes~~, bored geothermal heat
 355.11 exchangers, and elevator ~~shafts~~ borings.

355.12 Sec. 2. Minnesota Statutes 2016, section 103I.005, subdivision 2a, is amended to read:

355.13 Subd. 2a. **Certified representative.** "Certified representative" means a person certified
 355.14 by the commissioner to represent a well contractor, limited well/boring contractor, ~~monitoring~~
 355.15 environmental well contractor, or elevator boring contractor.

355.16 Sec. 3. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision
 355.17 to read:

355.18 Subd. 8a. **Environmental well.** "Environmental well" means an excavation 15 or more
 355.19 feet in depth that is drilled, cored, bored, washed, driven, dug, jetted, or otherwise constructed
 355.20 to:

355.21 (1) conduct physical, chemical, or biological testing of groundwater, and includes a
 355.22 groundwater quality monitoring or sampling well;

355.23 (2) lower a groundwater level to control or remove contamination in groundwater, and
 355.24 includes a remedial well and excludes horizontal trenches; or

355.25 (3) monitor or measure physical, chemical, radiological, or biological parameters of the
 355.26 earth and earth fluids, or for vapor recovery or venting systems. An environmental well
 355.27 includes an excavation used to:

355.28 (i) measure groundwater levels, including a piezometer;

355.29 (ii) determine groundwater flow direction or velocity;

356.1 (iii) measure earth properties such as hydraulic conductivity, bearing capacity, or
 356.2 resistance;

356.3 (iv) obtain samples of geologic materials for testing or classification; or

356.4 (v) remove or remediate pollution or contamination from groundwater or soil through
 356.5 the use of a vent, vapor recovery system, or sparge point.

356.6 Sec. 4. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision
 356.7 to read:

356.8 Subd. 8b. **Environmental well contractor.** "Environmental well contractor" means a
 356.9 person with an environmental well contractor's license issued by the commissioner.

356.10 Sec. 5. Minnesota Statutes 2016, section 103I.005, subdivision 12, is amended to read:

356.11 Subd. 12. **Limited well/boring contractor.** "Limited well/boring contractor" means a
 356.12 person with a limited well/boring contractor's license issued by the commissioner. Limited
 356.13 well/boring contractor's licenses are issued for:

356.14 (1) constructing, repairing, and sealing bored geothermal heat exchangers;

356.15 (2) installing, repairing, and modifying pitless units and pitless adaptors, well casings
 356.16 above the pitless unit or pitless adaptor, well screens, ~~or well diameters; constructing,~~
 356.17 ~~repairing, and sealing drive point wells or dug wells,~~ and well pumps and pumping
 356.18 equipment;

356.19 (3) constructing, repairing, and sealing dewatering wells; and

356.20 (4) sealing wells; ~~and installing well pumps or pumping equipment and borings.~~

356.21 Sec. 6. Minnesota Statutes 2016, section 103I.005, is amended by adding a subdivision
 356.22 to read:

356.23 Subd. 17a. **Temporary environmental well.** "Temporary environmental well" means
 356.24 an environmental well as defined in section 103I.005, subdivision 8a, that is sealed within
 356.25 72 hours of the time construction on the well begins.

356.26 Sec. 7. Minnesota Statutes 2016, section 103I.005, subdivision 20a, is amended to read:

356.27 Subd. 20a. **Water supply well.** "Water supply well" means a well that is not a dewatering
 356.28 well or ~~monitoring~~ environmental well and includes wells used:

356.29 (1) for potable water supply;

- 357.1 (2) for irrigation;
- 357.2 (3) for agricultural, commercial, or industrial water supply;
- 357.3 (4) for heating or cooling; and
- 357.4 (5) ~~as a remedial well; and~~
- 357.5 ~~(6)~~ for testing water yield for irrigation, commercial or industrial uses, residential supply,
- 357.6 or public water supply.

357.7 Sec. 8. Minnesota Statutes 2016, section 103I.005, subdivision 21, is amended to read:

357.8 Subd. 21. **Well.** "Well" means an excavation that is drilled, cored, bored, washed, driven,

357.9 dug, jetted, or otherwise constructed if the excavation is intended for the location, diversion,

357.10 artificial recharge, monitoring, testing, remediation, or acquisition of groundwater. Well

357.11 includes ~~monitoring~~ environmental wells, drive point wells, and dewatering wells. "Well"

357.12 does not include:

- 357.13 (1) an excavation by backhoe, or otherwise for temporary dewatering of groundwater
- 357.14 for nonpotable use during construction, if the depth of the excavation is 25 feet or less;
- 357.15 (2) an excavation made to obtain or prospect for oil, natural gas, minerals, or products
- 357.16 of mining or quarrying;
- 357.17 (3) an excavation to insert media to repressure oil or natural gas bearing formations or
- 357.18 to store petroleum, natural gas, or other products;
- 357.19 (4) an excavation for nonpotable use for wildfire suppression activities; or
- 357.20 (5) borings.

357.21 Sec. 9. Minnesota Statutes 2016, section 103I.101, subdivision 2, is amended to read:

357.22 Subd. 2. **Duties.** The commissioner shall:

- 357.23 (1) regulate the drilling, construction, modification, repair, and sealing of wells and
- 357.24 borings;
- 357.25 (2) examine and license:
- 357.26 (i) well contractors;
- 357.27 (ii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

358.1 (iii) persons modifying or repairing well casings above the pitless unit or adaptor, well
 358.2 screens, or well diameters; persons constructing, repairing, and sealing drive point wells or
 358.3 dug wells, and installing well pumps or pumping equipment;

358.4 (iv) persons constructing, repairing, and sealing dewatering wells;

358.5 (v) persons sealing wells; persons installing well pumps or pumping equipment or
 358.6 borings; and

358.7 (vi) persons excavating or drilling holes for the installation of elevator borings or
 358.8 hydraulic cylinders;

358.9 (3) ~~register~~ examine and ~~examine monitoring~~ license environmental well contractors;

358.10 (4) license explorers engaged in exploratory boring and examine individuals who
 358.11 supervise or oversee exploratory boring;

358.12 (5) after consultation with the commissioner of natural resources and the Pollution
 358.13 Control Agency, establish standards for the design, location, construction, repair, and sealing
 358.14 of wells and borings within the state; and

358.15 (6) issue permits for wells, groundwater thermal devices, bored geothermal heat
 358.16 exchangers, and elevator borings.

358.17 Sec. 10. Minnesota Statutes 2016, section 103I.101, subdivision 5, is amended to read:

358.18 Subd. 5. **Commissioner to adopt rules.** The commissioner shall adopt rules including:

358.19 (1) issuance of licenses for:

358.20 (i) qualified well contractors, ~~persons modifying or repairing well casings, well screens,~~
 358.21 ~~or well diameters;~~

358.22 (ii) ~~persons constructing, repairing, and sealing drive point wells or dug wells;~~

358.23 ~~(iii)~~ persons constructing, repairing, and sealing dewatering wells;

358.24 ~~(iv)~~ (iii) persons sealing wells or borings;

358.25 ~~(v)~~ (iv) persons installing, modifying, or repairing well casings, well screens, well
 358.26 diameters, and well pumps or pumping equipment;

358.27 ~~(vi)~~ (v) persons constructing, repairing, and sealing bored geothermal heat exchangers;
 358.28 **and**

358.29 ~~(vii)~~ (vi) persons constructing, repairing, and sealing elevator borings; and

358.30 (vii) persons constructing, repairing, and sealing environmental wells;

- 359.1 ~~(2)~~ issuance of registration for monitoring well contractors;
- 359.2 ~~(3)~~ establishment of conditions for examination and review of applications for license
359.3 and registration certification;
- 359.4 ~~(4)~~ (3) establishment of conditions for revocation and suspension of license and
359.5 registration certification;
- 359.6 ~~(5)~~ (4) establishment of minimum standards for design, location, construction, repair,
359.7 and sealing of wells and borings to implement the purpose and intent of this chapter;
- 359.8 ~~(6)~~ (5) establishment of a system for reporting on wells and borings drilled and sealed;
- 359.9 ~~(7)~~ (6) establishment of standards for the construction, maintenance, sealing, and water
359.10 quality monitoring of wells in areas of known or suspected contamination;
- 359.11 ~~(8)~~ (7) establishment of wellhead protection measures for wells serving public water
359.12 supplies;
- 359.13 ~~(9)~~ (8) establishment of procedures to coordinate collection of well and boring data with
359.14 other state and local governmental agencies;
- 359.15 ~~(10)~~ (9) establishment of criteria and procedures for submission of well and boring logs,
359.16 formation samples or well or boring cuttings, water samples, or other special information
359.17 required for and water resource mapping; and
- 359.18 ~~(11)~~ (10) establishment of minimum standards for design, location, construction,
359.19 maintenance, repair, sealing, safety, and resource conservation related to borings, including
359.20 exploratory borings as defined in section 103I.005, subdivision 9.

359.21 Sec. 11. Minnesota Statutes 2016, section 103I.101, subdivision 6, is amended to read:

359.22 Subd. 6. **Fees for variances.** The commissioner shall charge a nonrefundable application
359.23 fee of ~~\$235~~ \$275 to cover the administrative cost of processing a request for a variance or
359.24 modification of rules adopted by the commissioner under this chapter.

359.25 Sec. 12. Minnesota Statutes 2016, section 103I.105, is amended to read:

359.26 **103I.105 ADVISORY COUNCIL ON WELLS AND BORINGS.**

359.27 (a) The Advisory Council on Wells and Borings is established as an advisory council
359.28 to the commissioner. The advisory council shall consist of 18 voting members. Of the 18
359.29 voting members:

360.1 (1) one member must be from the Department of Health, appointed by the commissioner
360.2 of health;

360.3 (2) one member must be from the Department of Natural Resources, appointed by the
360.4 commissioner of natural resources;

360.5 (3) one member must be a member of the Minnesota Geological Survey of the University
360.6 of Minnesota, appointed by the director;

360.7 (4) one member must be a responsible individual for a licensed explorer;

360.8 (5) one member must be a certified representative of a licensed elevator boring contractor;

360.9 (6) two members must be members of the public who are not connected with the boring
360.10 or well drilling industry;

360.11 (7) one member must be from the Pollution Control Agency, appointed by the
360.12 commissioner of the Pollution Control Agency;

360.13 (8) one member must be from the Department of Transportation, appointed by the
360.14 commissioner of transportation;

360.15 (9) one member must be from the Board of Water and Soil Resources appointed by its
360.16 chair;

360.17 (10) one member must be a certified representative of a ~~monitoring~~ an environmental
360.18 well contractor;

360.19 (11) six members must be residents of this state appointed by the commissioner, who
360.20 are certified representatives of licensed well contractors, with not more than two from the
360.21 seven-county metropolitan area and at least four from other areas of the state who represent
360.22 different geographical regions; and

360.23 (12) one member must be a certified representative of a licensed bored geothermal heat
360.24 exchanger contractor.

360.25 (b) An appointee of the well drilling industry may not serve more than two consecutive
360.26 terms.

360.27 (c) The appointees to the advisory council from the well drilling industry must:

360.28 (1) have been residents of this state for at least three years before appointment; and

360.29 (2) have at least five years' experience in the well drilling business.

360.30 (d) The terms of the appointed members and the compensation and removal of all
360.31 members are governed by section 15.059.

361.1 Sec. 13. Minnesota Statutes 2016, section 103I.111, subdivision 6, is amended to read:

361.2 Subd. 6. **Unsealed wells and borings are public health nuisances.** A well or boring
361.3 that is required to be sealed under section 103I.301 but is not sealed is a public health
361.4 nuisance. A county may abate the unsealed well or boring with the same authority of a
361.5 community health board to abate a public health nuisance under section 145A.04, subdivision
361.6 8.

361.7 Sec. 14. Minnesota Statutes 2016, section 103I.111, subdivision 8, is amended to read:

361.8 Subd. 8. **Municipal regulation of drilling.** A municipality may regulate all drilling,
361.9 except well, elevator ~~shaft~~ boring, and exploratory drilling that is subject to the provisions
361.10 of this chapter, above, in, through, and adjacent to subsurface areas designated for mined
361.11 underground space development and existing mined underground space. The regulations
361.12 may prohibit, restrict, control, and require permits for the drilling.

361.13 Sec. 15. Minnesota Statutes 2016, section 103I.205, subdivision 1, is amended to read:

361.14 Subdivision 1. **Notification required.** (a) Except as provided in ~~paragraphs~~ paragraph
361.15 ~~(d) and (e)~~, a person may not construct a water-supply, dewatering, or environmental well
361.16 until a notification of the proposed well on a form prescribed by the commissioner is filed
361.17 with the commissioner with the filing fee in section 103I.208, and, when applicable, the
361.18 person has met the requirements of paragraph ~~(f)~~ (e). If after filing the well notification an
361.19 attempt to construct a well is unsuccessful, a new notification is not required unless the
361.20 information relating to the successful well has substantially changed. A notification is not
361.21 required prior to construction of a temporary environmental well.

361.22 (b) The property owner, the property owner's agent, or the ~~well~~ licensed contractor where
361.23 a well is to be located must file the well notification with the commissioner.

361.24 (c) The well notification under this subdivision preempts local permits and notifications,
361.25 and counties or home rule charter or statutory cities may not require a permit or notification
361.26 for wells unless the commissioner has delegated the permitting or notification authority
361.27 under section 103I.111.

361.28 (d) A person who is an individual that constructs a drive point water-supply well on
361.29 property owned or leased by the individual for farming or agricultural purposes or as the
361.30 individual's place of abode must notify the commissioner of the installation and location of
361.31 the well. The person must complete the notification form prescribed by the commissioner
361.32 and mail it to the commissioner by ten days after the well is completed. A fee may not be

362.1 charged for the notification. A person who sells drive point wells at retail must provide
 362.2 buyers with notification forms and informational materials including requirements regarding
 362.3 wells, their location, construction, and disclosure. The commissioner must provide the
 362.4 notification forms and informational materials to the sellers.

362.5 ~~(e) A person may not construct a monitoring well until a permit is issued by the~~
 362.6 ~~commissioner for the construction. If after obtaining a permit an attempt to construct a well~~
 362.7 ~~is unsuccessful, a new permit is not required as long as the initial permit is modified to~~
 362.8 ~~indicate the location of the successful well.~~

362.9 ~~(f)~~ (e) When the operation of a well will require an appropriation permit from the
 362.10 commissioner of natural resources, a person may not begin construction of the well until
 362.11 the person submits the following information to the commissioner of natural resources:

362.12 (1) the location of the well;

362.13 (2) the formation or aquifer that will serve as the water source;

362.14 (3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be
 362.15 requested in the appropriation permit; and

362.16 (4) other information requested by the commissioner of natural resources that is necessary
 362.17 to conduct the preliminary assessment required under section 103G.287, subdivision 1,
 362.18 paragraph (c).

362.19 The person may begin construction after receiving preliminary approval from the
 362.20 commissioner of natural resources.

362.21 Sec. 16. Minnesota Statutes 2016, section 103I.205, subdivision 2, is amended to read:

362.22 Subd. 2. **Emergency permit and notification exemptions.** The commissioner may
 362.23 adopt rules that modify the procedures for filing a well notification or well or boring permit
 362.24 if conditions occur that:

362.25 (1) endanger the public health and welfare or cause a need to protect the groundwater;
 362.26 or

362.27 (2) require the ~~monitoring environmental~~ well contractor, limited well/boring contractor,
 362.28 or well contractor to begin constructing a well or boring before obtaining a permit or
 362.29 notification.

363.1 Sec. 17. Minnesota Statutes 2016, section 103I.205, subdivision 3, is amended to read:

363.2 Subd. 3. **Maintenance permit.** (a) Except as provided under paragraph (b), a well that
363.3 is not in use must be sealed or have a maintenance permit.

363.4 (b) If ~~a monitoring~~ an environmental well or a dewatering well is not sealed by 14 months
363.5 after completion of construction, the owner of the property on which the well is located
363.6 must obtain and annually renew a maintenance permit from the commissioner.

363.7 Sec. 18. Minnesota Statutes 2016, section 103I.205, subdivision 4, is amended to read:

363.8 Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e),
363.9 section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct,
363.10 repair, or seal a well or boring unless the person has a well contractor's license in possession.

363.11 (b) A person may construct, repair, and seal ~~a monitoring~~ an environmental well if the
363.12 person:

363.13 (1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches
363.14 of civil or geological engineering;

363.15 (2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

363.16 (3) is a professional geoscientist licensed under sections 326.02 to 326.15;

363.17 (4) is a geologist certified by the American Institute of Professional Geologists; or

363.18 (5) meets the qualifications established by the commissioner in rule.

363.19 A person must ~~register with~~ be licensed by the commissioner as ~~a monitoring~~ an
363.20 environmental well contractor on forms provided by the commissioner.

363.21 (c) A person may do the following work with a limited well/boring contractor's license
363.22 in possession. A separate license is required for each of the ~~six~~ four activities:

363.23 (1) ~~installing, repairing, and modifying~~ installing, repairing, and modifying well screens ~~or~~ or pitless units ~~or~~ and pitless
363.24 adaptors, well pumps and pumping equipment, and well casings from the pitless adaptor or
363.25 pitless unit to the upper termination of the well casing;

363.26 (2) ~~constructing, repairing, and sealing drive point wells or dug wells;~~

363.27 (3) ~~installing well pumps or pumping equipment;~~

363.28 (4) ~~sealing wells and borings;~~

363.29 (5) (3) ~~constructing, repairing, or~~ and sealing dewatering wells; or

363.30 (6) (4) ~~constructing, repairing, or~~ and sealing bored geothermal heat exchangers.

364.1 (d) A person may construct, repair, and seal an elevator boring with an elevator boring
364.2 contractor's license.

364.3 (e) Notwithstanding other provisions of this chapter requiring a license ~~or registration~~,
364.4 a license ~~or registration~~ is not required for a person who complies with the other provisions
364.5 of this chapter if the person is:

364.6 (1) an individual who constructs a water-supply well on land that is owned or leased by
364.7 the individual and is used by the individual for farming or agricultural purposes or as the
364.8 individual's place of abode;

364.9 (2) an individual who performs labor or services for a contractor licensed ~~or registered~~
364.10 under the provisions of this chapter in connection with the construction, sealing, or repair
364.11 of a well or boring at the direction and under the personal supervision of a contractor licensed
364.12 ~~or registered~~ under the provisions of this chapter; or

364.13 (3) a licensed plumber who is repairing submersible pumps or water pipes associated
364.14 with well water systems if: (i) the repair location is within an area where there is no licensed
364.15 ~~or registered~~ well contractor within 50 miles, and (ii) the licensed plumber complies with
364.16 all relevant sections of the plumbing code.

364.17 Sec. 19. Minnesota Statutes 2016, section 103I.205, subdivision 5, is amended to read:

364.18 Subd. 5. **At-grade ~~monitoring~~ environmental wells.** At-grade ~~monitoring~~ environmental
364.19 wells are authorized without variance and may be installed for the purpose of evaluating
364.20 groundwater conditions or for use as a leak detection device. An at-grade ~~monitoring~~
364.21 environmental well must be installed in accordance with the rules of the commissioner. The
364.22 at-grade ~~monitoring~~ environmental wells must be installed with an impermeable double
364.23 locking cap approved by the commissioner and must be labeled environmental or monitoring
364.24 wells.

364.25 Sec. 20. Minnesota Statutes 2016, section 103I.205, subdivision 6, is amended to read:

364.26 Subd. 6. **Distance requirements for sources of contamination, buildings, gas pipes,**
364.27 **liquid propane tanks, and electric lines.** (a) A person may not place, construct, or install
364.28 an actual or potential source of contamination, building, gas pipe, liquid propane tank, or
364.29 electric line any closer to a well or boring than the isolation distances prescribed by the
364.30 commissioner by rule unless a variance has been prescribed by rule.

365.1 (b) The commissioner shall establish by rule reduced isolation distances for facilities
 365.2 which have safeguards in accordance with sections 18B.01, subdivision 26, and 18C.005,
 365.3 subdivision 29.

365.4 Sec. 21. Minnesota Statutes 2016, section 103I.208, subdivision 1, is amended to read:

365.5 Subdivision 1. **Well notification fee.** The well notification fee to be paid by a property
 365.6 owner is:

365.7 (1) for construction of a new water supply well, ~~\$235~~ \$275, which includes the state
 365.8 core function fee;

365.9 (2) for a well sealing, ~~\$65~~ \$75 for each well, which includes the state core function fee,
 365.10 except that a single fee of \$75 is required for monitoring all temporary environmental wells
 365.11 ~~constructed or~~ recorded on the sealing notification for a single property, having depths
 365.12 within a 25 foot range, and sealed within 48 ~~72~~ hours of start of construction, ~~a single fee~~
 365.13 ~~of \$65; and~~

365.14 (3) for construction of a dewatering well, ~~\$235~~ \$275, which includes the state core
 365.15 function fee, for each dewatering well except a dewatering project comprising five or more
 365.16 dewatering wells shall be assessed a single fee of ~~\$1,175~~ \$1,375 for the dewatering wells
 365.17 recorded on the notification; and

365.18 (4) for construction of an environmental well, \$275, which includes the state core function
 365.19 fee, except that a single fee of \$275 is required for all environmental wells recorded on the
 365.20 notification that are located on a single property, and except that no fee is required for
 365.21 construction of a temporary environmental well.

365.22 Sec. 22. Minnesota Statutes 2016, section 103I.208, subdivision 2, is amended to read:

365.23 Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

365.24 (1) for a water supply well that is not in use under a maintenance permit, \$175 annually;

365.25 (2) ~~for construction of a monitoring well, \$235, which includes the state core function~~
 365.26 ~~fee;~~

365.27 (3) ~~for a monitoring~~ an environmental well that is unsealed under a maintenance permit,
 365.28 \$175 annually except no fee is required for an environmental well owned by a federal
 365.29 agency, state agency, or local unit of government that is unsealed under a maintenance
 365.30 permit. "Local unit of government" means a statutory or home rule charter city, town, county,
 365.31 or soil and water conservation district, watershed district, an organization formed for the

366.1 joint exercise of powers under section 471.59, a community health board, or other special
366.2 purpose district or authority with local jurisdiction in water and related land resources
366.3 management;

366.4 ~~(4) for a monitoring well owned by a federal agency, state agency, or local unit of~~
366.5 ~~government that is unsealed under a maintenance permit, \$50 annually. "Local unit of~~
366.6 ~~government" means a statutory or home rule charter city, town, county, or soil and water~~
366.7 ~~conservation district, watershed district, an organization formed for the joint exercise of~~
366.8 ~~powers under section 471.59, a community health board, or other special purpose district~~
366.9 ~~or authority with local jurisdiction in water and related land resources management;~~

366.10 ~~(5) (3) for monitoring environmental wells used as a leak detection device at a single~~
366.11 ~~motor fuel retail outlet, a single petroleum bulk storage site excluding tank farms, or a single~~
366.12 ~~agricultural chemical facility site, the construction permit fee is \$235, which includes the~~
366.13 ~~state core function fee, per site regardless of the number of wells constructed on the site,~~
366.14 ~~and the annual fee for that are unsealed under a maintenance permit for unsealed monitoring~~
366.15 ~~wells is, \$175 annually per site regardless of the number of monitoring environmental wells~~
366.16 ~~located on site;~~

366.17 ~~(6) (4) for a groundwater thermal exchange device, in addition to the notification fee~~
366.18 ~~for water supply wells, \$235 \$275, which includes the state core function fee;~~

366.19 ~~(7) (5) for a bored geothermal heat exchanger with less than ten tons of heating/cooling~~
366.20 ~~capacity, \$235 \$275;~~

366.21 ~~(8) (6) for a bored geothermal heat exchanger with ten to 50 tons of heating/cooling~~
366.22 ~~capacity, \$475 \$515;~~

366.23 ~~(9) (7) for a bored geothermal heat exchanger with greater than 50 tons of heating/cooling~~
366.24 ~~capacity, \$700 \$740;~~

366.25 ~~(10) (8) for a dewatering well that is unsealed under a maintenance permit, \$175 annually~~
366.26 ~~for each dewatering well, except a dewatering project comprising more than five dewatering~~
366.27 ~~wells shall be issued a single permit for \$875 annually for dewatering wells recorded on~~
366.28 ~~the permit; and~~

366.29 ~~(11) (9) for an elevator boring, \$235 \$275 for each boring.~~

367.1 Sec. 23. Minnesota Statutes 2016, section 103I.235, is amended by adding a subdivision
367.2 to read:

367.3 Subd. 3. **Temporary environmental well and unsuccessful well exemption.** This
367.4 section does not apply to temporary environmental wells or unsuccessful wells that have
367.5 been sealed by a licensed contractor in compliance with this chapter.

367.6 Sec. 24. Minnesota Statutes 2016, section 103I.301, subdivision 1, is amended to read:

367.7 Subdivision 1. **Wells and borings.** (a) A property owner must have a well or boring
367.8 sealed if:

367.9 (1) the well or boring is contaminated or may contribute to the spread of contamination;

367.10 (2) the well or boring was attempted to be sealed but was not sealed according to the
367.11 provisions of this chapter; or

367.12 (3) the well or boring is located, constructed, or maintained in a manner that its continued
367.13 use or existence endangers groundwater quality or is a safety or health hazard.

367.14 (b) A well or boring that is not in use must be sealed unless the property owner has a
367.15 maintenance permit for the well.

367.16 (c) The property owner must have a well or boring sealed by a ~~registered or~~ licensed
367.17 person authorized to seal the well or boring, consistent with provisions of this chapter.

367.18 Sec. 25. Minnesota Statutes 2016, section 103I.301, subdivision 2, is amended to read:

367.19 Subd. 2. ~~Monitoring Environmental wells.~~ The owner of the property where a
367.20 ~~monitoring an environmental well~~ is located must have the ~~monitoring environmental well~~
367.21 sealed when the well is no longer in use. The owner must have a well contractor, limited
367.22 well/boring sealing contractor, or a ~~monitoring an environmental well~~ contractor seal the
367.23 ~~monitoring environmental well~~.

367.24 Sec. 26. Minnesota Statutes 2016, section 103I.315, subdivision 1, is amended to read:

367.25 Subdivision 1. **Order to seal well or boring.** The commissioner may order a property
367.26 owner to seal a well or boring if:

367.27 (1) the commissioner determines that without being sealed the well or boring is an
367.28 imminent threat to public health or public safety;

367.29 (2) the well or boring is required to be sealed under section 103I.301; or

368.1 (3) a well is ~~a monitoring~~ an environmental well or dewatering well and by 14 months
368.2 after construction of the well, the owner has not obtained a maintenance permit, or after a
368.3 maintenance permit has been issued the owner has not renewed a maintenance permit.

368.4 Sec. 27. Minnesota Statutes 2016, section 103I.501, is amended to read:

368.5 **103I.501 LICENSING AND REGULATION OF WELLS AND BORINGS.**

368.6 (a) The commissioner shall regulate and license:

368.7 (1) drilling, constructing, and repair of wells;

368.8 (2) sealing of wells;

368.9 (3) installing of well pumps and pumping equipment;

368.10 (4) excavating, drilling, repairing, and sealing of elevator borings;

368.11 (5) construction, repair, and sealing of environmental ~~bore holes~~ wells; and

368.12 (6) construction, repair, and sealing of bored geothermal heat exchangers.

368.13 (b) The commissioner shall examine and license well contractors, limited well/boring
368.14 contractors, and elevator boring contractors, and ~~examine and register monitoring~~
368.15 environmental well contractors.

368.16 (c) The commissioner shall license explorers engaged in exploratory boring and shall
368.17 examine persons who supervise or oversee exploratory boring.

368.18 Sec. 28. Minnesota Statutes 2016, section 103I.505, subdivision 1, is amended to read:

368.19 Subdivision 1. **Reciprocity authorized.** The commissioner may issue a license or ~~register~~
368.20 certify a person under this chapter, without giving an examination, if the person is licensed
368.21 or ~~registered~~ certified in another state and:

368.22 (1) the requirements for licensing or ~~registration~~ certification under which the well or
368.23 boring contractor was licensed or ~~registered~~ person was certified do not conflict with this
368.24 chapter;

368.25 (2) the requirements are of a standard not lower than that specified by the rules adopted
368.26 under this chapter; and

368.27 (3) equal reciprocal privileges are granted to licensees or ~~registrants~~ certified persons
368.28 of this state.

369.1 Sec. 29. Minnesota Statutes 2016, section 103I.505, subdivision 2, is amended to read:

369.2 Subd. 2. **Fees required.** A well or boring contractor or certified person must apply for
369.3 the license or ~~registration~~ certification and pay the fees under the provisions of this chapter
369.4 to receive a license or ~~registration~~ certification under this section.

369.5 Sec. 30. Minnesota Statutes 2016, section 103I.515, is amended to read:

369.6 **103I.515 LICENSES NOT TRANSFERABLE.**

369.7 A license or ~~registration~~ certification issued under this chapter is not transferable.

369.8 Sec. 31. Minnesota Statutes 2016, section 103I.525, subdivision 1, is amended to read:

369.9 Subdivision 1. **Certification application.** (a) A person must file an application and
369.10 application fee with the commissioner to represent a well contractor.

369.11 (b) The application must state the applicant's qualifications for certification as a
369.12 representative, and other information required by the commissioner. The application must
369.13 be on forms prescribed by the commissioner.

369.14 ~~(c) A person may apply as an individual if the person:~~

369.15 ~~(1) is not representing a firm, sole proprietorship, partnership, association, corporation,~~
369.16 ~~or other entity including the United States government, any interstate body, the state, and~~
369.17 ~~an agency, department, or political subdivision of the state; and~~

369.18 ~~(2) meets the well contractor certification and license requirements under this chapter.~~

369.19 Sec. 32. Minnesota Statutes 2016, section 103I.525, subdivision 2, is amended to read:

369.20 Subd. 2. **Certification fee.** (a) The application fee for certification as a representative
369.21 of a well contractor is \$75. The commissioner may not act on an application until the
369.22 application fee is paid.

369.23 (b) The renewal fee for certification as a representative of a well contractor is \$75. The
369.24 commissioner may not renew a certification until the renewal fee is paid.

369.25 (c) A certified representative must file an application and a renewal application fee to
369.26 renew the certification by the date stated in the certification. The renewal application must
369.27 include information that the certified representative has met continuing education
369.28 requirements established by the commissioner by rule.

370.1 Sec. 33. Minnesota Statutes 2016, section 103I.525, subdivision 5, is amended to read:

370.2 Subd. 5. **Bond.** (a) As a condition of being issued a well contractor's license, the applicant,
370.3 ~~except a person applying for an individual well contractor's license,~~ must submit a corporate
370.4 surety bond for \$25,000 approved by the commissioner. The bond must be conditioned to
370.5 pay the state on performance of work in this state that is not in compliance with this chapter
370.6 or rules adopted under this chapter. The bond is in lieu of other license bonds required by
370.7 a political subdivision of the state.

370.8 (b) From proceeds of the bond, the commissioner may compensate persons injured or
370.9 suffering financial loss because of a failure of the applicant to perform work or duties in
370.10 compliance with this chapter or rules adopted under this chapter.

370.11 Sec. 34. Minnesota Statutes 2016, section 103I.525, subdivision 6, is amended to read:

370.12 Subd. 6. **License fee.** The fee for a well contractor's license is \$250, ~~except the fee for~~
370.13 ~~an individual well contractor's license is \$75.~~

370.14 Sec. 35. Minnesota Statutes 2016, section 103I.525, subdivision 8, is amended to read:

370.15 Subd. 8. **Renewal.** (a) A licensee must file an application and a renewal application fee
370.16 to renew the license by the date stated in the license.

370.17 (b) The renewal application fee for a well contractor's license is \$250, ~~except the fee for~~
370.18 ~~an individual well contractor's license is \$75.~~

370.19 (c) The renewal application must include information that the certified representative
370.20 of the applicant has met continuing education requirements established by the commissioner
370.21 by rule.

370.22 (d) At the time of the renewal, the commissioner must have on file all properly completed
370.23 well and boring construction reports, well and boring sealing reports, reports of elevator
370.24 borings, water sample analysis reports, well and boring permits, and well notifications for
370.25 work conducted by the licensee since the last license renewal.

370.26 Sec. 36. Minnesota Statutes 2016, section 103I.531, subdivision 2, is amended to read:

370.27 Subd. 2. **Certification fee.** (a) The application fee for certification as a representative
370.28 of a limited well/boring contractor is \$75. The commissioner may not act on an application
370.29 until the application fee is paid.

370.30 (b) The renewal fee for certification as a representative of a limited well/boring contractor
370.31 is \$75. The commissioner may not renew a certification until the renewal fee is paid.

371.1 (c) The fee for three or more limited well/boring contractor certifications is \$225.

371.2 (d) A certified representative must file an application and a renewal application fee to
371.3 renew the certification by the date stated in the certification. The renewal application must
371.4 include information that the certified representative has met continuing education
371.5 requirements established by the commissioner by rule.

371.6 Sec. 37. Minnesota Statutes 2016, section 103I.531, subdivision 5, is amended to read:

371.7 Subd. 5. **Bond.** (a) As a condition of being issued a limited well/boring contractor's
371.8 license for ~~constructing, repairing, and sealing drive point wells or dug wells,~~ sealing wells
371.9 ~~or~~ and borings, constructing, repairing, and sealing dewatering wells, or constructing,
371.10 repairing, and sealing bored geothermal heat exchangers, the applicant must submit a
371.11 corporate surety bond for \$10,000 approved by the commissioner. As a condition of being
371.12 issued a limited well/boring contractor's license for installing ~~or~~ repairing, and modifying
371.13 well pumps and pumping equipment, well screens ~~or~~ pitless units or pitless adaptors,
371.14 and well casings from the pitless adaptor or pitless unit to the upper termination of the well
371.15 casing, ~~or installing well pumps or pumping equipment,~~ the applicant must submit a corporate
371.16 surety bond for \$2,000 approved by the commissioner. The bonds required in this paragraph
371.17 must be conditioned to pay the state on performance of work in this state that is not in
371.18 compliance with this chapter or rules adopted under this chapter. The bonds are in lieu of
371.19 other license bonds required by a political subdivision of the state.

371.20 (b) From proceeds of a bond required in paragraph (a), the commissioner may compensate
371.21 persons injured or suffering financial loss because of a failure of the applicant to perform
371.22 work or duties in compliance with this chapter or rules adopted under this chapter.

371.23 Sec. 38. Minnesota Statutes 2016, section 103I.535, subdivision 2, is amended to read:

371.24 Subd. 2. **Certification fee.** (a) The application fee for certification as a representative
371.25 of an elevator boring contractor is \$75. The commissioner may not act on an application
371.26 until the application fee is paid.

371.27 (b) The renewal fee for certification as a representative of an elevator boring contractor
371.28 is \$75. The commissioner may not renew a certification until the renewal fee is paid.

371.29 (c) A certified representative must file an application and a renewal application fee to
371.30 renew the certification by the date stated in the certification. The renewal application must
371.31 include information that the certified representative has met continuing education
371.32 requirements established by the commissioner by rule.

372.1 Sec. 39. Minnesota Statutes 2016, section 103I.535, subdivision 6, is amended to read:

372.2 Subd. 6. **License fee.** The fee for an elevator ~~shaft~~ boring contractor's license is \$75.

372.3 Sec. 40. Minnesota Statutes 2016, section 103I.541, subdivision 1, is amended to read:

372.4 Subdivision 1. **Registration Certification.** A person seeking ~~registration as a monitoring~~
372.5 certification to represent an environmental well contractor must meet examination and
372.6 experience requirements adopted by the commissioner by rule.

372.7 Sec. 41. Minnesota Statutes 2016, section 103I.541, subdivision 2, is amended to read:

372.8 Subd. 2. **Validity.** ~~A monitoring~~ An environmental well contractor's registration
372.9 certification is valid until the date prescribed in the ~~registration~~ certification by the
372.10 commissioner.

372.11 Sec. 42. Minnesota Statutes 2016, section 103I.541, subdivision 2a, is amended to read:

372.12 Subd. 2a. **Certification application.** (a) An individual must submit an application and
372.13 application fee to the commissioner to apply for certification as a representative of a
372.14 ~~monitoring an environmental~~ well contractor.

372.15 (b) The application must be on forms prescribed by the commissioner. The application
372.16 must state the applicant's qualifications for the certification, and other information required
372.17 by the commissioner.

372.18 Sec. 43. Minnesota Statutes 2016, section 103I.541, subdivision 2b, is amended to read:

372.19 Subd. 2b. **Issuance of ~~registration~~ license.** If a person employs a certified representative,
372.20 submits the bond under subdivision 3, and pays the ~~registration~~ license fee of \$75 for a
372.21 ~~monitoring an environmental~~ well contractor ~~registration~~ license, the commissioner shall
372.22 issue a ~~monitoring an environmental~~ well contractor ~~registration~~ license to the applicant.
372.23 The fee for an individual registration is \$75. The commissioner may not act on an application
372.24 until the application fee is paid.

372.25 Sec. 44. Minnesota Statutes 2016, section 103I.541, subdivision 2c, is amended to read:

372.26 Subd. 2c. **Certification fee.** (a) The application fee for certification as a representative
372.27 of a ~~monitoring an environmental~~ well contractor is \$75. The commissioner may not act on
372.28 an application until the application fee is paid.

373.1 (b) The renewal fee for certification as a representative of a ~~monitoring~~ an environmental
373.2 well contractor is \$75. The commissioner may not renew a certification until the renewal
373.3 fee is paid.

373.4 (c) A certified representative must file an application and a renewal application fee to
373.5 renew the certification by the date stated in the certification. The renewal application must
373.6 include information that the certified representative has met continuing education
373.7 requirements established by the commissioner by rule.

373.8 Sec. 45. Minnesota Statutes 2016, section 103I.541, subdivision 2e, is amended to read:

373.9 Subd. 2e. **Issuance of certification.** If the applicant meets the experience requirements
373.10 established by rule and passes the examination as determined by the commissioner, the
373.11 commissioner shall issue the applicant a certification to represent a ~~monitoring~~ an
373.12 environmental well contractor.

373.13 Sec. 46. Minnesota Statutes 2016, section 103I.541, subdivision 3, is amended to read:

373.14 Subd. 3. **Bond.** (a) As a condition of being issued a ~~monitoring~~ an environmental well
373.15 contractor's ~~registration~~ license, the applicant must submit a corporate surety bond for
373.16 \$10,000 approved by the commissioner. The bond must be conditioned to pay the state on
373.17 performance of work in this state that is not in compliance with this chapter or rules adopted
373.18 under this chapter. The bond is in lieu of other license bonds required by a political
373.19 subdivision of the state.

373.20 (b) From proceeds of the bond, the commissioner may compensate persons injured or
373.21 suffering financial loss because of a failure of the applicant to perform work or duties in
373.22 compliance with this chapter or rules adopted under this chapter.

373.23 Sec. 47. Minnesota Statutes 2016, section 103I.541, subdivision 4, is amended to read:

373.24 Subd. 4. **License renewal.** (a) A person must file an application and a renewal application
373.25 fee to renew the ~~registration~~ license by the date stated in the ~~registration~~ license.

373.26 (b) The renewal application fee for a ~~monitoring~~ an environmental well contractor's
373.27 ~~registration~~ license is \$75.

373.28 (c) The renewal application must include information that the certified representative
373.29 of the applicant has met continuing education requirements established by the commissioner
373.30 by rule.

374.1 (d) At the time of the renewal, the commissioner must have on file all well and boring
374.2 construction reports, well and boring sealing reports, well permits, and notifications for
374.3 work conducted by the ~~registered~~ licensed person since the last ~~registration~~ license renewal.

374.4 Sec. 48. Minnesota Statutes 2016, section 103I.541, subdivision 5, is amended to read:

374.5 Subd. 5. **Incomplete or late renewal.** If a ~~registered~~ licensed person submits a renewal
374.6 application after the required renewal date:

374.7 (1) the ~~registered~~ licensed person must include a late fee of \$75; and

374.8 (2) the ~~registered~~ licensed person may not conduct activities authorized by the ~~monitoring~~
374.9 environmental well contractor's ~~registration~~ license until the renewal application, renewal
374.10 application fee, late fee, and all other information required in subdivision 4 are submitted.

374.11 Sec. 49. Minnesota Statutes 2016, section 103I.545, is amended to read:

374.12 **103I.545 REGISTRATION OF DRILLING MACHINES AND HOISTS**
374.13 **REQUIRED.**

374.14 Subdivision 1. **Drilling machine.** (a) A person may not use a drilling machine such as
374.15 a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license
374.16 ~~or registration~~ under this chapter unless the drilling machine is registered with the
374.17 commissioner.

374.18 (b) A person must apply for the registration on forms prescribed by the commissioner
374.19 and submit a \$75 registration fee.

374.20 (c) A registration is valid for one year.

374.21 Subd. 2. **Hoist.** (a) A person may not use a machine such as a hoist for an activity
374.22 requiring a license ~~or registration~~ under this chapter to repair wells or borings, seal wells
374.23 or borings, or install pumps unless the machine is registered with the commissioner.

374.24 (b) A person must apply for the registration on forms prescribed by the commissioner
374.25 and submit a \$75 registration fee.

374.26 (c) A registration is valid for one year.

374.27 Sec. 50. **[103I.550] LIMITED PUMP, PITLESS, OR DUG WELL/DRIVE POINT**
374.28 **CONTRACTOR.**

374.29 Subdivision 1. **Limited pump or pitless license or certification.** A person with a limited
374.30 well/boring contractor's license or certification to install well pumps and pumping equipment;

375.1 or a person with a limited well/boring contractor's license or certification to install, repair,
375.2 and modify pitless units and pitless adapters, well casings above the pitless unit or pitless
375.3 adapter, and well screens and well diameters, will be issued a combined license or
375.4 certification to: (1) install well pumps and pumping equipment; and (2) install, repair, and
375.5 modify pitless units and pitless adapters, well casings above the pitless unit or pitless adapter,
375.6 well screens, and well diameters.

375.7 Subd. 2. **Limited dug well/drive point license or certification.** A person with a limited
375.8 well/boring contractor's license or certification to construct, repair, and seal drive point
375.9 wells and dug wells will be issued a well contractor's license or certification.

375.10 Sec. 51. Minnesota Statutes 2016, section 103I.601, subdivision 2, is amended to read:

375.11 Subd. 2. **License required to make borings.** (a) Except as provided in paragraph (d),
375.12 a person must not make an exploratory boring without an explorer's license. The fee for an
375.13 explorer's license is \$75. The explorer's license is valid until the date prescribed in the license
375.14 by the commissioner.

375.15 (b) A person must file an application and renewal application fee to renew the explorer's
375.16 license by the date stated in the license. The renewal application fee is \$75.

375.17 (c) If the licensee submits an application fee after the required renewal date, the licensee:

375.18 (1) must include a late fee of \$75; and

375.19 (2) may not conduct activities authorized by an explorer's license until the renewal
375.20 application, renewal application fee, late fee, and sealing reports required in subdivision 9
375.21 are submitted.

375.22 (d) An explorer must designate a responsible individual to supervise and oversee the
375.23 making of exploratory borings.

375.24 (1) Before an individual supervises or oversees an exploratory boring, the individual
375.25 must file an application and application fee of \$75 to qualify as a certified responsible
375.26 individual.

375.27 (2) The individual must take and pass an examination relating to construction, location,
375.28 and sealing of exploratory borings. A professional engineer or geoscientist licensed under
375.29 sections 326.02 to 326.15 or a professional geologist certified by the American Institute of
375.30 Professional Geologists is not required to take the examination required in this subdivision,
375.31 but must be certified as a responsible individual to supervise an exploratory boring.

376.1 (3) The individual must file an application and a renewal fee of \$75 to renew the
376.2 responsible individual's certification by the date stated in the certification. If the certified
376.3 responsible individual submits an application fee after the renewal date, the certified
376.4 responsible individual must include a late fee of \$75 and may not supervise or oversee
376.5 exploratory borings until the renewal application, application fee, and late fee are submitted.

376.6 Sec. 52. Minnesota Statutes 2016, section 103I.601, subdivision 4, is amended to read:

376.7 Subd. 4. **Notification and map of borings.** (a) By ten days before beginning exploratory
376.8 boring, an explorer must submit to the commissioner of health a notification of the proposed
376.9 boring on a form prescribed by the commissioner, and a fee of \$275 for each exploratory
376.10 boring.

376.11 (b) By ten days before beginning exploratory boring, an explorer must submit to the
376.12 commissioners of health and natural resources a county road map having a scale of one-half
376.13 inch equal to one mile, as prepared by the Department of Transportation, or a 7.5 minute
376.14 series topographic map (1:24,000 scale), as prepared by the United States Geological Survey,
376.15 showing the location of each proposed exploratory boring to the nearest estimated 40 acre
376.16 parcel. Exploratory boring that is proposed on the map may not be commenced later than
376.17 180 days after submission of the map, unless a new map is submitted.

376.18 Sec. 53. Minnesota Statutes 2016, section 103I.711, subdivision 1, is amended to read:

376.19 Subdivision 1. **Impoundment.** The commissioner may apply to district court for a
376.20 warrant authorizing seizure and impoundment of all drilling machines or hoists owned or
376.21 used by a person. The court shall issue an impoundment order upon the commissioner's
376.22 showing that a person is constructing, repairing, or sealing wells or borings or installing
376.23 pumps or pumping equipment or excavating holes for installing elevator ~~shafts~~ borings
376.24 without a license or registration as required under this chapter. A sheriff on receipt of the
376.25 warrant must seize and impound all drilling machines and hoists owned or used by the
376.26 person. A person from whom equipment is seized under this subdivision may file an action
376.27 in district court for the purpose of establishing that the equipment was wrongfully seized.

376.28 Sec. 54. Minnesota Statutes 2016, section 103I.715, subdivision 2, is amended to read:

376.29 Subd. 2. **Gross misdemeanors.** A person is guilty of a gross misdemeanor who:

376.30 (1) willfully violates a provision of this chapter or order of the commissioner;

377.1 (2) engages in the business of drilling or making wells, sealing wells, installing pumps
377.2 or pumping equipment, or constructing elevator ~~shafts~~ borings without a license required
377.3 by this chapter; or

377.4 (3) engages in the business of exploratory boring without an exploratory borer's license
377.5 under this chapter.

377.6 Sec. 55. [137.67] MINNESOTA BIOMEDICINE AND BIOETHICS INNOVATION
377.7 GRANTS.

377.8 Subdivision 1. Grants. (a) The steering committee of the University of Minnesota and
377.9 Mayo Foundation partnership shall award grants to entities that apply for a grant under this
377.10 subdivision to fund innovations and research in biomedicine and bioethics. Grant funds
377.11 must be used to fund biomedical and bioethical research, and related clinical translation
377.12 and commercialization activities in this state. Entities must apply for a grant in a form and
377.13 manner specified by the steering committee. The steering committee shall use the following
377.14 criteria to award grants under this subdivision:

377.15 (1) the likelihood that the research will lead to a new discovery;

377.16 (2) the prospects for commercialization of the research;

377.17 (3) the likelihood that the research will strengthen Minnesota's economy through the
377.18 creation of new businesses, increased public or private funding for research in Minnesota,
377.19 or attracting additional clinicians and researchers to Minnesota; and

377.20 (4) whether the proposed research includes a bioethics research plan to ensure the research
377.21 is conducted using ethical research practices.

377.22 (b) Projects that include the acquisition or use of human fetal tissue are not eligible for
377.23 grants under this subdivision. For purposes of this paragraph, "human fetal tissue" has the
377.24 meaning given in United States Code, title 42, section 289g-1(f).

377.25 Subd. 2. Consultation. In awarding grants under subdivision 1, the steering committee
377.26 may consult with interested parties who are able to provide technical information, advice,
377.27 and recommendations on grant projects and awards. Interested parties with whom the steering
377.28 committee may consult include but are not limited to representatives of private industries
377.29 with expertise in biomedical research, bioethical research, clinical translation,
377.30 commercialization, and medical venture financing.

378.1 Sec. 56. [144.0572] CRIMINAL HISTORY BACKGROUND CHECKS ON
378.2 APPLICANTS, LICENSEES, AND OTHER OCCUPATIONS REGULATED BY
378.3 COMMISSIONER OF HEALTH.

378.4 Subdivision 1. Criminal history background check requirements. (a) Beginning
378.5 January 1, 2018, an applicant for initial licensure, temporary licensure, or relicensure after
378.6 a lapse in licensure as an audiologist or speech-language pathologist, or an applicant for
378.7 initial certification as a hearing instrument dispenser, must submit to a criminal history
378.8 records check of state data completed by the Bureau of Criminal Apprehension (BCA) and
378.9 a national criminal history records check, including a search of the records of the Federal
378.10 Bureau of Investigation (FBI).

378.11 (b) Beginning January 1, 2020, an applicant for a renewal license or certificate as an
378.12 audiologist, speech-language pathologist, or hearing instrument dispenser who was licensed
378.13 or obtained a certificate before January 1, 2018, must submit to a criminal history records
378.14 check of state data completed by the BCA and a national criminal history records check,
378.15 including a search of the records of the FBI.

378.16 (c) An applicant must submit to a background study under chapter 245C.

378.17 (d) The criminal history records check must be structured so that any new crimes that
378.18 an applicant or licensee or certificate holder commits after the initial background check are
378.19 flagged in the BCA's or FBI's database and reported back to the commissioner of human
378.20 services.

378.21 Subd. 2. Procedures. (a) The commissioner shall contract with the Department of Human
378.22 Services to process the criminal history background check requirements through NETStudy
378.23 2.0, as defined in section 245C.02.

378.24 (b) The Department of Human Services shall conduct the criminal history background
378.25 checks according to section 144.057, except that:

378.26 (1) all applicants must submit to a fingerprint-based criminal history records check of
378.27 state data completed by the BCA and a national criminal history records check, including
378.28 a search of the records of the FBI;

378.29 (2) the Department of Human Services shall complete the check and the study and notify
378.30 the commissioner of health if the applicant, licensee, or certificate holder has a criminal
378.31 history as defined in section 245C.15; and

378.32 (3) the Department of Human Services shall simultaneously conduct a background study
378.33 on each applicant according to chapter 245C.

379.1 (c) When making a determination whether to issue a license, deny a license, or issue a
379.2 conditional license or other credential to practice an occupation regulated by the Department
379.3 of Health, the commissioner or the commissioner's designee shall evaluate a criminal
379.4 conviction, guilty plea, Alford plea, judicial determination, or preponderance of evidence
379.5 to determine an applicant's risk of harm using the criteria in section 364.03.

379.6 (d) Before taking disciplinary action against an applicant or a licensee based on a criminal
379.7 conviction, judicial determination, admission in court, Alford plea, or preponderance of
379.8 evidence, the commissioner of health shall provide the applicant or licensee an opportunity
379.9 to complete or challenge the accuracy of the criminal history information. The applicant or
379.10 licensee shall have 30 calendar days following notice from the commissioner of the intent
379.11 to deny licensure or take disciplinary action to request an opportunity to correct or complete
379.12 the record prior to the commissioner taking disciplinary action. The commissioner shall
379.13 provide the applicant up to 180 days to challenge the accuracy or completeness of the report
379.14 with the agency responsible for the record. This subdivision does not affect the right of the
379.15 subject of the data to contest the accuracy or completeness under section 13.04, subdivision
379.16 4.

379.17 (e) The checks and studies must be structured so that any new crimes that an applicant
379.18 or licensee commits after the initial background check are flagged in the BCA's or FBI's
379.19 database and reported back to the commissioner of human services.

379.20 Subd. 3. **Applicant, licensee, or other regulated individual's responsibilities.** (a)
379.21 Applicants, licensees, and individuals seeking a credential to practice one of the public
379.22 health occupations listed in subdivision 1 must submit a complete criminal history records
379.23 check consent form, a complete background study consent form, and a full set of fingerprints
379.24 as required by the Department of Human Services in section 245C.05.

379.25 (b) The applicant or license holder is responsible for paying to the Department of Human
379.26 Services all fees associated with the preparation of the fingerprints, the criminal records
379.27 check consent form, and the criminal background check.

379.28 Sec. 57. **[144.059] PALLIATIVE CARE ADVISORY COUNCIL.**

379.29 Subdivision 1. **Membership.** The Palliative Care Advisory Council shall consist of 18
379.30 public members.

379.31 Subd. 2. **Public members.** (a) The commissioner shall appoint, in the manner provided
379.32 in section 15.0597, 18 public members, including the following:

380.1 (1) two physicians, of which one is certified by the American Board of Hospice and
380.2 Palliative Medicine;

380.3 (2) two registered nurses or advanced practice registered nurses, of which one is certified
380.4 by the National Board for Certification of Hospice and Palliative Nurses;

380.5 (3) one care coordinator experienced in working with people with serious or chronic
380.6 illness and their families;

380.7 (4) one spiritual counselor experienced in working with people with serious or chronic
380.8 illness and their families;

380.9 (5) three licensed health professionals, such as complementary and alternative health
380.10 care practitioners, dietitians or nutritionists, pharmacists, or physical therapists, who are
380.11 neither physicians nor nurses, but who have experience as members of a palliative care
380.12 interdisciplinary team working with people with serious or chronic illness and their families;

380.13 (6) one licensed social worker experienced in working with people with serious or chronic
380.14 illness and their families;

380.15 (7) four patients or personal caregivers experienced with serious or chronic illness;

380.16 (8) one representative of a health plan company;

380.17 (9) one physician assistant that is a member of the American Academy of Hospice and
380.18 Palliative Medicine; and

380.19 (10) two members from any of the categories described in clauses (1) to (9).

380.20 (b) Council membership must include, where possible, representation that is racially,
380.21 culturally, linguistically, geographically, and economically diverse.

380.22 (c) The council must include at least six members who reside outside Anoka, Carver,
380.23 Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Sibley, Stearns,
380.24 Washington, or Wright Counties.

380.25 (d) To the extent possible, council membership must include persons who have experience
380.26 in palliative care research, palliative care instruction in a medical or nursing school setting,
380.27 palliative care services for veterans as a provider or recipient, or pediatric care.

380.28 (e) Council membership must include health professionals who have palliative care work
380.29 experience or expertise in palliative care delivery models in a variety of inpatient, outpatient,
380.30 and community settings, including acute care, long-term care, or hospice, with a variety of
380.31 populations, including pediatric, youth, and adult patients.

381.1 Subd. 3. **Term.** Members of the council shall serve for a term of three years and may
381.2 be reappointed. Members shall serve until their successors have been appointed.

381.3 Subd. 4. **Administration.** The commissioner or the commissioner's designee shall
381.4 provide meeting space and administrative services for the council.

381.5 Subd. 5. **Chairs.** At the council's first meeting, and biannually thereafter, the members
381.6 shall elect a chair and a vice-chair whose duties shall be established by the council.

381.7 Subd. 6. **Meeting.** The council shall meet at least twice yearly.

381.8 Subd. 7. **No compensation.** Public members of the council serve without compensation
381.9 or reimbursement for expenses.

381.10 Subd. 8. **Duties.** (a) The council shall consult with and advise the commissioner on
381.11 matters related to the establishment, maintenance, operation, and outcomes evaluation of
381.12 palliative care initiatives in the state.

381.13 (b) By February 15 of each year, the council shall submit to the chairs and ranking
381.14 minority members of the committees of the senate and the house of representatives with
381.15 primary jurisdiction over health care a report containing:

381.16 (1) the advisory council's assessment of the availability of palliative care in the state;

381.17 (2) the advisory council's analysis of barriers to greater access to palliative care; and

381.18 (3) recommendations for legislative action, with draft legislation to implement the
381.19 recommendations.

381.20 (c) The Department of Health shall publish the report each year on the department's Web
381.21 site.

381.22 Subd. 9. **Open meetings.** The council is subject to the requirements of chapter 13D.

381.23 Subd. 10. **Sunset.** The council shall sunset January 1, 2025.

381.24 Sec. 58. **[144.1215] AUTHORIZATION TO USE HANDHELD DENTAL X-RAY**
381.25 **EQUIPMENT.**

381.26 Subdivision 1. **Definition; handheld dental x-ray equipment.** For purposes of this
381.27 section, "handheld dental x-ray equipment" means x-ray equipment that is used to take
381.28 dental radiographs, is designed to be handheld during operation, and is operated by an
381.29 individual authorized to take dental radiographs under chapter 150A.

382.1 Subd. 2. Use authorized. (a) Handheld dental x-ray equipment may be used if the
382.2 equipment:

382.3 (1) has been approved for human use by the United States Food and Drug Administration
382.4 and is being used in a manner consistent with that approval; and

382.5 (2) utilizes a backscatter shield that:

382.6 (i) is composed of a leaded polymer or a substance with a substantially equivalent
382.7 protective capacity;

382.8 (ii) has at least 0.25 millimeters of lead or lead-shielding equivalent; and

382.9 (iii) is permanently affixed to the handheld dental x-ray equipment.

382.10 (b) The use of handheld dental x-ray equipment is prohibited if the equipment's
382.11 backscatter shield is broken or not permanently affixed to the system.

382.12 (c) The use of handheld dental x-ray equipment shall not be limited to situations in which
382.13 it is impractical to transfer the patient to a stationary x-ray system.

382.14 (d) Handheld dental x-ray equipment must be stored when not in use, by being secured
382.15 in a restricted, locked area of the facility.

382.16 (e) Handheld dental x-ray equipment must be calibrated initially and at intervals that
382.17 must not exceed 24 months. Calibration must include the test specified in Minnesota Rules,
382.18 part 4732.1100, subpart 11.

382.19 (f) Notwithstanding Minnesota Rules, part 4732.0880, subpart 2, item C, the tube housing
382.20 and the position-indicating device of handheld dental x-ray equipment may be handheld
382.21 during an exposure.

382.22 Subd. 3. Exemptions from certain shielding requirements. Handheld dental x-ray
382.23 equipment used according to this section and according to manufacturer instructions is
382.24 exempt from the following requirements for the equipment:

382.25 (1) shielding requirements in Minnesota Rules, part 4732.0365, item B; and

382.26 (2) requirements for the location of the x-ray control console or utilization of a protective
382.27 barrier in Minnesota Rules, part 4732.0800, subpart 2, item B, subitems (2) and (3), provided
382.28 the equipment utilizes a backscatter shield that satisfies the requirements in subdivision 2,
382.29 paragraph (a), clause (2).

382.30 Subd. 4. Compliance with rules. A registrant using handheld dental x-ray equipment
382.31 shall otherwise comply with Minnesota Rules, chapter 4732.

383.1 Sec. 59. Minnesota Statutes 2016, section 144.122, is amended to read:

383.2 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

383.3 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
 383.4 filing with the commissioner as prescribed by statute and for the issuance of original and
 383.5 renewal permits, licenses, registrations, and certifications issued under authority of the
 383.6 commissioner. The expiration dates of the various licenses, permits, registrations, and
 383.7 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
 383.8 application and examination fees and a penalty fee for renewal applications submitted after
 383.9 the expiration date of the previously issued permit, license, registration, and certification.
 383.10 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
 383.11 registrations, and certifications when the application therefor is submitted during the last
 383.12 three months of the permit, license, registration, or certification period. Fees proposed to
 383.13 be prescribed in the rules shall be first approved by the Department of Management and
 383.14 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
 383.15 in an amount so that the total fees collected by the commissioner will, where practical,
 383.16 approximate the cost to the commissioner in administering the program. All fees collected
 383.17 shall be deposited in the state treasury and credited to the state government special revenue
 383.18 fund unless otherwise specifically appropriated by law for specific purposes.

383.19 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
 383.20 and environmental laboratories, and for environmental and medical laboratory services
 383.21 provided by the department, without complying with paragraph (a) or chapter 14. Fees
 383.22 charged for environment and medical laboratory services provided by the department must
 383.23 be approximately equal to the costs of providing the services.

383.24 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
 383.25 conducted at clinics held by the services for children with disabilities program. All receipts
 383.26 generated by the program are annually appropriated to the commissioner for use in the
 383.27 maternal and child health program.

383.28 (d) The commissioner shall set license fees for hospitals and nursing homes that are not
 383.29 boarding care homes at the following levels:

383.30	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
383.31	Healthcare Organizations (JCAHO) and	
383.32	American Osteopathic Association (AOA)	
383.33	hospitals	
383.34	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
383.35	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
383.36		<u>\$183 plus \$100 per bed between July 1, 2018,</u>

384.1 and June 30, 2019. \$183 plus \$105 per bed
 384.2 beginning July 1, 2019.

384.3 The commissioner shall set license fees for outpatient surgical centers, boarding care
 384.4 homes, and supervised living facilities at the following levels:

384.5	Outpatient surgical centers	\$3,712
384.6	Boarding care homes	\$183 plus \$91 per bed
384.7	Supervised living facilities	\$183 plus \$91 per bed.

384.8 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
 384.9 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
 384.10 or later.

384.11 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants
 384.12 the following fees to cover the cost of any initial certification surveys required to determine
 384.13 a provider's eligibility to participate in the Medicare or Medicaid program:

384.14	Prospective payment surveys for hospitals	\$	900
384.15	Swing bed surveys for nursing homes	\$	1,200
384.16	Psychiatric hospitals	\$	1,400
384.17	Rural health facilities	\$	1,100
384.18	Portable x-ray providers	\$	500
384.19	Home health agencies	\$	1,800
384.20	Outpatient therapy agencies	\$	800
384.21	End stage renal dialysis providers	\$	2,100
384.22	Independent therapists	\$	800
384.23	Comprehensive rehabilitation outpatient facilities	\$	1,200
384.24	Hospice providers	\$	1,700
384.25	Ambulatory surgical providers	\$	1,800
384.26	Hospitals	\$	4,200
384.27	Other provider categories or additional	Actual surveyor costs: average	
384.28	resurveys required to complete initial	surveyor cost x number of hours for	
384.29	certification	the survey process.	

384.30 These fees shall be submitted at the time of the application for federal certification and
 384.31 shall not be refunded. All fees collected after the date that the imposition of fees is not
 384.32 prohibited by federal law shall be deposited in the state treasury and credited to the state
 384.33 government special revenue fund.

385.1 Sec. 60. Minnesota Statutes 2016, section 144.1501, subdivision 2, is amended to read:

385.2 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness
385.3 program account is established. The commissioner of health shall use money from the
385.4 account to establish a loan forgiveness program:

385.5 (1) for medical residents and mental health professionals agreeing to practice in designated
385.6 rural areas or underserved urban communities or specializing in the area of pediatric
385.7 psychiatry;

385.8 (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach
385.9 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program
385.10 at the undergraduate level or the equivalent at the graduate level;

385.11 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care
385.12 facility for persons with developmental disability; ~~or~~ a hospital if the hospital owns and
385.13 operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by
385.14 the nurse is in the nursing home; a housing with services establishment as defined in section
385.15 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43,
385.16 subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing
385.17 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
385.18 level;

385.19 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720
385.20 hours per year in their designated field in a postsecondary program at the undergraduate
385.21 level or the equivalent at the graduate level. The commissioner, in consultation with the
385.22 Healthcare Education-Industry Partnership, shall determine the health care fields where the
385.23 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory
385.24 technology, radiologic technology, and surgical technology;

385.25 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses
385.26 who agree to practice in designated rural areas; and

385.27 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
385.28 encounters to state public program enrollees or patients receiving sliding fee schedule
385.29 discounts through a formal sliding fee schedule meeting the standards established by the
385.30 United States Department of Health and Human Services under Code of Federal Regulations,
385.31 title 42, section 51, chapter 303.

385.32 (b) Appropriations made to the account do not cancel and are available until expended,
385.33 except that at the end of each biennium, any remaining balance in the account that is not

386.1 committed by contract and not needed to fulfill existing commitments shall cancel to the
386.2 fund.

386.3 **Sec. 61. [144.1505] HEALTH PROFESSIONALS CLINICAL TRAINING**
386.4 **EXPANSION GRANT PROGRAM.**

386.5 **Subdivision 1. Definitions.** For purposes of this section, the following definitions apply:

386.6 (1) "eligible advanced practice registered nurse program" means a program that is located
386.7 in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level
386.8 advanced practice registered nurse program by the Commission on Collegiate Nursing
386.9 Education or by the Accreditation Commission for Education in Nursing, or is a candidate
386.10 for accreditation;

386.11 (2) "eligible dental therapy program" means a dental therapy education program or
386.12 advanced dental therapy education program that is located in Minnesota and is either:

386.13 (i) approved by the Board of Dentistry; or

386.14 (ii) currently accredited by the Commission on Dental Accreditation;

386.15 (3) "eligible mental health professional program" means a program that is located in
386.16 Minnesota and is listed as a mental health professional program by the appropriate accrediting
386.17 body for clinical social work, psychology, marriage and family therapy, or licensed
386.18 professional clinical counseling, or is a candidate for accreditation;

386.19 (4) "eligible pharmacy program" means a program that is located in Minnesota and is
386.20 currently accredited as a doctor of pharmacy program by the Accreditation Council on
386.21 Pharmacy Education;

386.22 (5) "eligible physician assistant program" means a program that is located in Minnesota
386.23 and is currently accredited as a physician assistant program by the Accreditation Review
386.24 Commission on Education for the Physician Assistant, or is a candidate for accreditation;

386.25 (6) "mental health professional" means an individual providing clinical services in the
386.26 treatment of mental illness who meets one of the qualifications under section 245.462,
386.27 subdivision 18; and

386.28 (7) "project" means a project to establish or expand clinical training for physician
386.29 assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced
386.30 dental therapists, or mental health professionals in Minnesota.

386.31 **Subd. 2. Program.** (a) The commissioner of health shall award health professional
386.32 training site grants to eligible physician assistant, advanced practice registered nurse,

387.1 pharmacy, dental therapy, and mental health professional programs to plan and implement
387.2 expanded clinical training. A planning grant shall not exceed \$75,000, and a training grant
387.3 shall not exceed \$150,000 for the first year, \$100,000 for the second year, and \$50,000 for
387.4 the third year per program.

387.5 (b) Funds may be used for:

387.6 (1) establishing or expanding clinical training for physician assistants, advanced practice
387.7 registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental
387.8 health professionals in Minnesota;

387.9 (2) recruitment, training, and retention of students and faculty;

387.10 (3) connecting students with appropriate clinical training sites, internships, practicums,
387.11 or externship activities;

387.12 (4) travel and lodging for students;

387.13 (5) faculty, student, and preceptor salaries, incentives, or other financial support;

387.14 (6) development and implementation of cultural competency training;

387.15 (7) evaluations;

387.16 (8) training site improvements, fees, equipment, and supplies required to establish,
387.17 maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy,
387.18 dental therapy, or mental health professional training program; and

387.19 (9) supporting clinical education in which trainees are part of a primary care team model.

387.20 Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse,
387.21 pharmacy, dental therapy, and mental health professional programs seeking a grant shall
387.22 apply to the commissioner. Applications must include a description of the number of
387.23 additional students who will be trained using grant funds; attestation that funding will be
387.24 used to support an increase in the number of clinical training slots; a description of the
387.25 problem that the proposed project will address; a description of the project, including all
387.26 costs associated with the project, sources of funds for the project, detailed uses of all funds
387.27 for the project, and the results expected; and a plan to maintain or operate any component
387.28 included in the project after the grant period. The applicant must describe achievable
387.29 objectives, a timetable, and roles and capabilities of responsible individuals in the
387.30 organization.

387.31 Subd. 4. **Consideration of applications.** The commissioner shall review each application
387.32 to determine whether or not the application is complete and whether the program and the

388.1 project are eligible for a grant. In evaluating applications, the commissioner shall score each
388.2 application based on factors including, but not limited to, the applicant's clarity and
388.3 thoroughness in describing the project and the problems to be addressed, the extent to which
388.4 the applicant has demonstrated that the applicant has made adequate provisions to ensure
388.5 proper and efficient operation of the training program once the grant project is completed,
388.6 the extent to which the proposed project is consistent with the goal of increasing access to
388.7 primary care and mental health services for rural and underserved urban communities, the
388.8 extent to which the proposed project incorporates team-based primary care, and project
388.9 costs and use of funds.

388.10 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant
388.11 to be given to an eligible program based on the relative score of each eligible program's
388.12 application, other relevant factors discussed during the review, and the funds available to
388.13 the commissioner. Appropriations made to the program do not cancel and are available until
388.14 expended. During the grant period, the commissioner may require and collect from programs
388.15 receiving grants any information necessary to evaluate the program.

388.16 Sec. 62. **[144.4199] PUBLIC HEALTH RESPONSE CONTINGENCY ACCOUNT.**

388.17 Subdivision 1. **Public health response contingency account.** A public health response
388.18 contingency account is created in the special revenue fund in the state treasury. Money in
388.19 the public health response contingency account does not cancel and is appropriated to the
388.20 commissioner of health for the purposes specified in subdivision 4 when the determination
388.21 criteria in subdivision 3 and the requirements in subdivisions 5, paragraph (a), and 7, are
388.22 satisfied.

388.23 Subd. 2. **Definition.** For purposes of this section, "public health response" means
388.24 immediate public health activities required to protect the health and safety of the public due
388.25 to pandemic influenza or an outbreak of a communicable or infectious disease.

388.26 Subd. 3. **Determination criteria.** The commissioner may make expenditures from the
388.27 public health response contingency account only if:

388.28 (1) the commissioner determines the pandemic influenza or outbreak of a communicable
388.29 or infectious disease requires a public health response;

388.30 (2) the commissioner determines that the public health response is reasonably expected
388.31 to require supplies, equipment, personnel, and other resources in excess of the resources
388.32 available for public health response and preparedness activities in the affected jurisdictions;
388.33 and

389.1 (3) the commissioner has notified the relevant federal agency that the pandemic influenza
389.2 or communicable or infectious disease:

389.3 (i) is reasonably expected to require the evacuation of the impacted population, relocation
389.4 of seriously ill or injured persons to temporary care facilities, or the provision of replacement
389.5 essential community services;

389.6 (ii) poses a probability of a large number of deaths, serious injuries, or long-term
389.7 disabilities in the affected population;

389.8 (iii) involves widespread exposure to an infectious agent that poses a significant risk of
389.9 substantial future harm to a large number of people in the affected area; or

389.10 (iv) poses a significant risk of harm to a large number of people or a high rate of morbidity
389.11 or mortality in the affected population.

389.12 Subd. 4. **Uses of funds.** (a) When the determination criteria in subdivision 3 are satisfied
389.13 and the commissioner has complied with subdivisions 5, paragraph (a), and 7, the
389.14 commissioner may make expenditures from the public health response contingency account
389.15 for the following purposes attributable to a public health response:

389.16 (1) staffing;

389.17 (2) information technology;

389.18 (3) supplies, equipment, and services to protect people in the affected area or population,
389.19 health care providers, and public safety workers;

389.20 (4) training for and coordination with local public health departments and health care
389.21 providers;

389.22 (5) communication with and outreach to affected areas or populations;

389.23 (6) to provide a state match for federal assistance obtained for the public health response;

389.24 (7) laboratory testing, including enhancements to laboratory capacity necessary to conduct
389.25 testing related to the event, and supplies, equipment, shipping, and security;

389.26 (8) the purchase of vaccines, antibiotics, antivirals, and other medical resources to prevent
389.27 the spread of the pandemic influenza or communicable or infectious disease or to treat
389.28 related medical conditions;

389.29 (9) reimbursement to community health boards or other local units of government for
389.30 incurred costs for the goods and services listed in clauses (1) to (8) that are attributable to
389.31 the public health response;

390.1 (10) reimbursement to health care organizations and health care providers for incurred
390.2 costs that are attributable to the public health response; and

390.3 (11) funding to support other state agencies for costs incurred by those agencies that are
390.4 attributable to the public health response.

390.5 (b) Money in the account must not be used to increase the total number of full-time
390.6 equivalent permanent employees at the Department of Health, unless expressly authorized
390.7 by law. Money in the account shall be used only for public health response activities to
390.8 protect the health and safety of the public.

390.9 Subd. 5. **Assistance from other sources.** (a) As a condition of making expenditures
390.10 from the public health response contingency account, the commissioner must seek any
390.11 appropriate assistance from other available sources, including the federal government, to
390.12 assist with costs attributable to the public health response.

390.13 (b) If the commissioner recovers eligible costs for the public health response from a
390.14 nonstate source after making expenditures from the public health response contingency
390.15 account, the commissioner shall reimburse the public health response contingency account
390.16 for those costs, up to the amount recovered for eligible costs from the nonstate source.

390.17 Subd. 6. **Emergency management authority.** Nothing in this section shall be construed
390.18 to limit the emergency management authority of the governor or any local or county
390.19 organization for emergency management under chapter 12 or other law.

390.20 Subd. 7. **Notice and expenditure review.** (a) For pandemic influenza or an outbreak of
390.21 a communicable or infectious disease that begins on or after July 1, 2017, if the commissioner
390.22 determines that a public health response to pandemic influenza or an outbreak of a
390.23 communicable or infectious disease may require the diversion of Department of Health staff
390.24 or resources, the commissioner shall provide written notice to the chairs and ranking minority
390.25 members of the legislative committees with jurisdiction over health and human services
390.26 policy and finance with information on the event requiring the public health response, the
390.27 public health response that may be required, and estimates of the staff hours and resources
390.28 that the commissioner may need to divert to provide the public health response. For pandemic
390.29 influenza or an outbreak of a communicable or infectious disease that begins prior to July
390.30 1, 2017, the commissioner must provide the notice required by this paragraph no later than
390.31 July 10, 2017.

390.32 (b) Prior to authorizing expenditures from the public health response contingency account,
390.33 the commissioner shall seek review and recommendation from the Legislative Advisory
390.34 Commission according to the procedures in section 3.3005, subdivision 5, that would

391.1 otherwise apply if the funds were federal funds. The commissioner is prohibited from seeking
391.2 review and recommendation for any expenditures for public health response activities that
391.3 were made before the commissioner provided the notice required in paragraph (a).

391.4 Subd. 8. **Report.** By January 15 of each year, the commissioner shall submit a report to
391.5 the chairs and ranking minority members of the house of representatives Ways and Means
391.6 Committee, the senate Finance Committee, and the house of representatives and senate
391.7 committees with jurisdiction over health and human services finance, detailing expenditures
391.8 made in the previous calendar year from the public health response contingency account.

391.9 Sec. 63. Minnesota Statutes 2016, section 144.4961, subdivision 3, is amended to read:

391.10 Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules establishing licensure
391.11 requirements and work standards relating to indoor radon in dwellings and other buildings,
391.12 with the exception of newly constructed Minnesota homes according to section 326B.106,
391.13 subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions
391.14 in matters concerning the presence, effects, measurement, and mitigation of risks of radon
391.15 in dwellings and other buildings. Rules adopted by the commissioner under this subdivision
391.16 are effective beginning January 1, 2019.

391.17 Sec. 64. Minnesota Statutes 2016, section 144.4961, subdivision 4, is amended to read:

391.18 Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after
391.19 January 1, ~~2018~~ 2019, must have a radon mitigation system tag provided by the
391.20 commissioner. A radon mitigation professional must attach the tag to the radon mitigation
391.21 system in a visible location.

391.22 Sec. 65. Minnesota Statutes 2016, section 144.4961, subdivision 5, is amended to read:

391.23 Subd. 5. **License required annually.** Effective January 1, ~~2018~~ 2019, a license is required
391.24 annually for every person, firm, or corporation that performs a service for compensation to
391.25 detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or
391.26 performs a service to mitigate radon in the indoor atmosphere.

391.27 Sec. 66. Minnesota Statutes 2016, section 144.551, subdivision 1, is amended to read:

391.28 Subdivision 1. **Restricted construction or modification.** (a) The following construction
391.29 or modification may not be commenced:

391.30 (1) any erection, building, alteration, reconstruction, modernization, improvement,
391.31 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed

392.1 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
392.2 to another, or otherwise results in an increase or redistribution of hospital beds within the
392.3 state; and

392.4 (2) the establishment of a new hospital.

392.5 (b) This section does not apply to:

392.6 (1) construction or relocation within a county by a hospital, clinic, or other health care
392.7 facility that is a national referral center engaged in substantial programs of patient care,
392.8 medical research, and medical education meeting state and national needs that receives more
392.9 than 40 percent of its patients from outside the state of Minnesota;

392.10 (2) a project for construction or modification for which a health care facility held an
392.11 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
392.12 certificate;

392.13 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
392.14 appeal results in an order reversing the denial;

392.15 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
392.16 section 2;

392.17 (5) a project involving consolidation of pediatric specialty hospital services within the
392.18 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
392.19 of pediatric specialty hospital beds among the hospitals being consolidated;

392.20 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
392.21 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
392.22 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
392.23 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
392.24 hospitals must be reinstated at the capacity that existed on each site before the relocation;

392.25 (7) the relocation or redistribution of hospital beds within a hospital building or
392.26 identifiable complex of buildings provided the relocation or redistribution does not result
392.27 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
392.28 one physical site or complex to another; or (iii) redistribution of hospital beds within the
392.29 state or a region of the state;

392.30 (8) relocation or redistribution of hospital beds within a hospital corporate system that
392.31 involves the transfer of beds from a closed facility site or complex to an existing site or
392.32 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
392.33 transferred; (ii) the capacity of the site or complex to which the beds are transferred does

393.1 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
393.2 health systems agency boundary in place on July 1, 1983; and (iv) the relocation or
393.3 redistribution does not involve the construction of a new hospital building;

393.4 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
393.5 County that primarily serves adolescents and that receives more than 70 percent of its
393.6 patients from outside the state of Minnesota;

393.7 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
393.8 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
393.9 and (ii) the total licensed capacity of the replacement hospital, either at the time of
393.10 construction of the initial building or as the result of future expansion, will not exceed 70
393.11 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

393.12 (11) the relocation of licensed hospital beds from an existing state facility operated by
393.13 the commissioner of human services to a new or existing facility, building, or complex
393.14 operated by the commissioner of human services; from one regional treatment center site
393.15 to another; or from one building or site to a new or existing building or site on the same
393.16 campus;

393.17 (12) the construction or relocation of hospital beds operated by a hospital having a
393.18 statutory obligation to provide hospital and medical services for the indigent that does not
393.19 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
393.20 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
393.21 Medical Center to Regions Hospital under this clause;

393.22 (13) a construction project involving the addition of up to 31 new beds in an existing
393.23 nonfederal hospital in Beltrami County;

393.24 (14) a construction project involving the addition of up to eight new beds in an existing
393.25 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

393.26 (15) a construction project involving the addition of 20 new hospital beds used for
393.27 rehabilitation services in an existing hospital in Carver County serving the southwest
393.28 suburban metropolitan area. Beds constructed under this clause shall not be eligible for
393.29 reimbursement under medical assistance or MinnesotaCare;

393.30 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
393.31 of up to two psychiatric facilities or units for children provided that the operation of the
393.32 facilities or units have received the approval of the commissioner of human services;

394.1 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
394.2 services in an existing hospital in Itasca County;

394.3 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
394.4 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
394.5 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
394.6 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

394.7 (19) a critical access hospital established under section 144.1483, clause (9), and section
394.8 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
394.9 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
394.10 to the extent that the critical access hospital does not seek to exceed the maximum number
394.11 of beds permitted such hospital under federal law;

394.12 (20) notwithstanding section 144.552, a project for the construction of a new hospital
394.13 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

394.14 (i) the project, including each hospital or health system that will own or control the entity
394.15 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
394.16 Council as of March 1, 2006;

394.17 (ii) the entity that will hold the new hospital license will be owned or controlled by one
394.18 or more not-for-profit hospitals or health systems that have previously submitted a plan or
394.19 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
394.20 have been found to be in the public interest by the commissioner of health as of April 1,
394.21 2005;

394.22 (iii) the new hospital's initial inpatient services must include, but are not limited to,
394.23 medical and surgical services, obstetrical and gynecological services, intensive care services,
394.24 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
394.25 services, and emergency room services;

394.26 (iv) the new hospital:

394.27 (A) will have the ability to provide and staff sufficient new beds to meet the growing
394.28 needs of the Maple Grove service area and the surrounding communities currently being
394.29 served by the hospital or health system that will own or control the entity that will hold the
394.30 new hospital license;

394.31 (B) will provide uncompensated care;

394.32 (C) will provide mental health services, including inpatient beds;

395.1 (D) will be a site for workforce development for a broad spectrum of health-care-related
395.2 occupations and have a commitment to providing clinical training programs for physicians
395.3 and other health care providers;

395.4 (E) will demonstrate a commitment to quality care and patient safety;

395.5 (F) will have an electronic medical records system, including physician order entry;

395.6 (G) will provide a broad range of senior services;

395.7 (H) will provide emergency medical services that will coordinate care with regional
395.8 providers of trauma services and licensed emergency ambulance services in order to enhance
395.9 the continuity of care for emergency medical patients; and

395.10 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
395.11 the control of the entity holding the new hospital license; and

395.12 (v) as of 30 days following submission of a written plan, the commissioner of health
395.13 has not determined that the hospitals or health systems that will own or control the entity
395.14 that will hold the new hospital license are unable to meet the criteria of this clause;

395.15 (21) a project approved under section 144.553;

395.16 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
395.17 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
395.18 is approved by the Cass County Board;

395.19 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
395.20 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
395.21 a separately licensed 13-bed skilled nursing facility;

395.22 (24) notwithstanding section 144.552, a project for the construction and expansion of a
395.23 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
395.24 who are under 21 years of age on the date of admission. The commissioner conducted a
395.25 public interest review of the mental health needs of Minnesota and the Twin Cities
395.26 metropolitan area in 2008. No further public interest review shall be conducted for the
395.27 construction or expansion project under this clause;

395.28 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
395.29 commissioner finds the project is in the public interest after the public interest review
395.30 conducted under section 144.552 is complete; ~~or~~

395.31 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
395.32 of Maple Grove, exclusively for patients who are under 21 years of age on the date of

396.1 admission, if the commissioner finds the project is in the public interest after the public
396.2 interest review conducted under section 144.552 is complete;

396.3 (ii) this project shall serve patients in the continuing care benefit program under section
396.4 256.9693. The project may also serve patients not in the continuing care benefit program;
396.5 and

396.6 (iii) if the project ceases to participate in the continuing care benefit program, the
396.7 commissioner must complete a subsequent public interest review under section 144.552. If
396.8 the project is found not to be in the public interest, the license must be terminated six months
396.9 from the date of that finding. If the commissioner of human services terminates the contract
396.10 without cause or reduces per diem payment rates for patients under the continuing care
396.11 benefit program below the rates in effect for services provided on December 31, 2015, the
396.12 project may cease to participate in the continuing care benefit program and continue to
396.13 operate without a subsequent public interest review; or

396.14 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
396.15 in Hennepin County that is exclusively for patients who are under 21 years of age on the
396.16 date of admission.

396.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

396.18 Sec. 67. Minnesota Statutes 2016, section 144.99, subdivision 1, is amended to read:

396.19 Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections
396.20 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14),
396.21 and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385;
396.22 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98;
396.23 144.992; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders,
396.24 stipulation agreements, settlements, compliance agreements, licenses, registrations,
396.25 certificates, and permits adopted or issued by the department or under any other law now
396.26 in force or later enacted for the preservation of public health may, in addition to provisions
396.27 in other statutes, be enforced under this section.

396.28 Sec. 68. Minnesota Statutes 2016, section 144A.472, subdivision 7, is amended to read:

396.29 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant
396.30 seeking temporary home care licensure must submit the following application fee to the
396.31 commissioner along with a completed application:

396.32 (1) for a basic home care provider, \$2,100; or

397.1 (2) for a comprehensive home care provider, \$4,200.

397.2 (b) A home care provider who is filing a change of ownership as required under
397.3 subdivision 5 must submit the following application fee to the commissioner, along with
397.4 the documentation required for the change of ownership:

397.5 (1) for a basic home care provider, \$2,100; or

397.6 (2) for a comprehensive home care provider, \$4,200.

397.7 (c) For the period ending June 30, 2018, a home care provider who is seeking to renew
397.8 the provider's license shall pay a fee to the commissioner based on revenues derived from
397.9 the provision of home care services during the calendar year prior to the year in which the
397.10 application is submitted, according to the following schedule:

397.11 License Renewal Fee

397.12 Provider Annual Revenue	Fee
397.13 greater than \$1,500,000	\$6,625
397.14 greater than \$1,275,000 and no more than 397.15 \$1,500,000	\$5,797
397.16 greater than \$1,100,000 and no more than 397.17 \$1,275,000	\$4,969
397.18 greater than \$950,000 and no more than 397.19 \$1,100,000	\$4,141
397.20 greater than \$850,000 and no more than \$950,000	\$3,727
397.21 greater than \$750,000 and no more than \$850,000	\$3,313
397.22 greater than \$650,000 and no more than \$750,000	\$2,898
397.23 greater than \$550,000 and no more than \$650,000	\$2,485
397.24 greater than \$450,000 and no more than \$550,000	\$2,070
397.25 greater than \$350,000 and no more than \$450,000	\$1,656
397.26 greater than \$250,000 and no more than \$350,000	\$1,242
397.27 greater than \$100,000 and no more than \$250,000	\$828
397.28 greater than \$50,000 and no more than \$100,000	\$500
397.29 greater than \$25,000 and no more than \$50,000	\$400
397.30 no more than \$25,000	\$200

397.31 (d) For the period between July 1, 2018, and June 30, 2019, a home care provider who
397.32 is seeking to renew the provider's license shall pay a fee to the commissioner in an amount
397.33 that is ten percent higher than the applicable fee in paragraph (c). A home care provider's
397.34 fee shall be based on revenues derived from the provision of home care services during the
397.35 calendar year prior to the year in which the application is submitted.

398.1 (e) Beginning July 1, 2019, a home care provider who is seeking to renew the provider's
 398.2 license shall pay a fee to the commissioner based on revenues derived from the provision
 398.3 of home care services during the calendar year prior to the year in which the application is
 398.4 submitted, according to the following schedule:

398.5 License Renewal Fee

398.6 <u>Provider Annual Revenue</u>	<u>Fee</u>
398.7 <u>greater than \$1,500,000</u>	<u>\$7,651</u>
398.8 <u>greater than \$1,275,000 and no more than</u> 398.9 <u>\$1,500,000</u>	<u>\$6,695</u>
398.10 <u>greater than \$1,100,000 and no more than</u> 398.11 <u>\$1,275,000</u>	<u>\$5,739</u>
398.12 <u>greater than \$950,000 and no more than</u> 398.13 <u>\$1,100,000</u>	<u>\$4,783</u>
398.14 <u>greater than \$850,000 and no more than \$950,000</u>	<u>\$4,304</u>
398.15 <u>greater than \$750,000 and no more than \$850,000</u>	<u>\$3,826</u>
398.16 <u>greater than \$650,000 and no more than \$750,000</u>	<u>\$3,347</u>
398.17 <u>greater than \$550,000 and no more than \$650,000</u>	<u>\$2,870</u>
398.18 <u>greater than \$450,000 and no more than \$550,000</u>	<u>\$2,391</u>
398.19 <u>greater than \$350,000 and no more than \$450,000</u>	<u>\$1,913</u>
398.20 <u>greater than \$250,000 and no more than \$350,000</u>	<u>\$1,434</u>
398.21 <u>greater than \$100,000 and no more than \$250,000</u>	<u>\$957</u>
398.22 <u>greater than \$50,000 and no more than \$100,000</u>	<u>\$577</u>
398.23 <u>greater than \$25,000 and no more than \$50,000</u>	<u>\$462</u>
398.24 <u>no more than \$25,000</u>	<u>\$231</u>

398.25 ~~(d)~~ (f) If requested, the home care provider shall provide the commissioner information
 398.26 to verify the provider's annual revenues or other information as needed, including copies
 398.27 of documents submitted to the Department of Revenue.

398.28 ~~(e)~~ (g) At each annual renewal, a home care provider may elect to pay the highest renewal
 398.29 fee for its license category, and not provide annual revenue information to the commissioner.

398.30 ~~(f)~~ (h) A temporary license or license applicant, or temporary licensee or licensee that
 398.31 knowingly provides the commissioner incorrect revenue amounts for the purpose of paying
 398.32 a lower license fee, shall be subject to a civil penalty in the amount of double the fee the
 398.33 provider should have paid.

398.34 ~~(g)~~ (i) Fees and penalties collected under this section shall be deposited in the state
 398.35 treasury and credited to the state government special revenue fund. All fees are
 398.36 nonrefundable. Fees collected under paragraphs (c), (d), and (e) are nonrefundable even if

399.1 received before July 1, 2017, for temporary licenses or licenses being issued effective July
399.2 1, 2017, or later.

399.3 ~~(h) The license renewal fee schedule in this subdivision is effective July 1, 2016.~~

399.4 Sec. 69. Minnesota Statutes 2016, section 144A.4799, subdivision 3, is amended to read:

399.5 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
399.6 advice regarding regulations of Department of Health licensed home care providers in this
399.7 chapter, including advice on the following:

399.8 (1) community standards for home care practices;

399.9 (2) enforcement of licensing standards and whether certain disciplinary actions are
399.10 appropriate;

399.11 (3) ways of distributing information to licensees and consumers of home care;

399.12 (4) training standards;

399.13 (5) identifying emerging issues and opportunities in the home care field, including the
399.14 use of technology in home and telehealth capabilities;

399.15 (6) allowable home care licensing modifications and exemptions, including a method
399.16 for an integrated license with an existing license for rural licensed nursing homes to provide
399.17 limited home care services in an adjacent independent living apartment building owned by
399.18 the licensed nursing home; and

399.19 (7) recommendations for studies using the data in section 62U.04, subdivision 4, including
399.20 but not limited to studies concerning costs related to dementia and chronic disease among
399.21 an elderly population over 60 and additional long-term care costs, as described in section
399.22 62U.10, subdivision 6.

399.23 (b) The advisory council shall perform other duties as directed by the commissioner.

399.24 (c) The advisory council shall annually review the balance of the account in the state
399.25 government special revenue fund described in section 144A.474, subdivision 11, paragraph
399.26 (i), and make annual recommendations by January 15 directly to the chairs and ranking
399.27 minority members of the legislative committees with jurisdiction over health and human
399.28 services regarding appropriations to the commissioner for the purposes in section 144A.474,
399.29 subdivision 11, paragraph (i).

400.1 Sec. 70. Minnesota Statutes 2016, section 144A.70, is amended by adding a subdivision
400.2 to read:

400.3 Subd. 4a. **Nurse.** "Nurse" means a licensed practical nurse as defined in section 148.171,
400.4 subdivision 8, or a registered nurse as defined in section 148.171, subdivision 20.

400.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

400.6 Sec. 71. Minnesota Statutes 2016, section 144A.70, subdivision 6, is amended to read:

400.7 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services
400.8 agency" means a person, firm, corporation, partnership, or association engaged for hire in
400.9 the business of providing or procuring temporary employment in health care facilities for
400.10 nurses, nursing assistants, nurse aides, and orderlies,~~and other licensed health professionals.~~
400.11 Supplemental nursing services agency does not include an individual who only engages in
400.12 providing the individual's services on a temporary basis to health care facilities. Supplemental
400.13 nursing services agency does not include a professional home care agency licensed under
400.14 section 144A.471 that only provides staff to other home care providers.

400.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

400.16 Sec. 72. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

400.17 Subd. 2. **Contents of contract.** A housing with services contract, which need not be
400.18 entitled as such to comply with this section, shall include at least the following elements in
400.19 itself or through supporting documents or attachments:

400.20 (1) the name, street address, and mailing address of the establishment;

400.21 (2) the name and mailing address of the owner or owners of the establishment and, if
400.22 the owner or owners is not a natural person, identification of the type of business entity of
400.23 the owner or owners;

400.24 (3) the name and mailing address of the managing agent, through management agreement
400.25 or lease agreement, of the establishment, if different from the owner or owners;

400.26 (4) the name and address of at least one natural person who is authorized to accept service
400.27 of process on behalf of the owner or owners and managing agent;

400.28 (5) a statement describing the registration and licensure status of the establishment and
400.29 any provider providing health-related or supportive services under an arrangement with the
400.30 establishment;

400.31 (6) the term of the contract;

401.1 (7) a description of the services to be provided to the resident in the base rate to be paid
 401.2 by resident, including a delineation of the portion of the base rate that constitutes rent and
 401.3 a delineation of charges for each service included in the base rate;

401.4 (8) a description of any additional services, including home care services, available for
 401.5 an additional fee from the establishment directly or through arrangements with the
 401.6 establishment, and a schedule of fees charged for these services;

401.7 (9) a ~~description~~ conspicuous notice informing the tenant of the policy concerning the
 401.8 conditions under which and the process through which the contract may be modified,
 401.9 amended, or terminated, including whether a move to a different room or sharing a room
 401.10 would be required in the event that the tenant can no longer pay the current rent;

401.11 (10) a description of the establishment's complaint resolution process available to residents
 401.12 including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

401.13 (11) the resident's designated representative, if any;

401.14 (12) the establishment's referral procedures if the contract is terminated;

401.15 (13) requirements of residency used by the establishment to determine who may reside
 401.16 or continue to reside in the housing with services establishment;

401.17 (14) billing and payment procedures and requirements;

401.18 (15) a statement regarding the ability of residents to receive services from service
 401.19 providers with whom the establishment does not have an arrangement;

401.20 (16) a statement regarding the availability of public funds for payment for residence or
 401.21 services in the establishment; and

401.22 (17) a statement regarding the availability of and contact information for long-term care
 401.23 consultation services under section 256B.0911 in the county in which the establishment is
 401.24 located.

401.25 Sec. 73. Minnesota Statutes 2016, section 144D.06, is amended to read:

401.26 **144D.06 OTHER LAWS.**

401.27 In addition to registration under this chapter, a housing with services establishment must
 401.28 comply with chapter 504B and the provisions of section 325F.72, and shall obtain and
 401.29 maintain all other licenses, permits, registrations, or other governmental approvals required
 401.30 of it ~~in addition to registration under this chapter~~. A housing with services establishment is

402.1 ~~subject to the provisions of section 325F.72 and chapter 504B~~ not required to obtain a
402.2 lodging license under chapter 157 and related rules.

402.3 **EFFECTIVE DATE.** This section is effective August 1, 2017.

402.4 Sec. 74. **[144H.01] DEFINITIONS.**

402.5 Subdivision 1. **Application.** The terms defined in this section apply to this chapter.

402.6 Subd. 2. **Basic services.** "Basic services" includes but is not limited to:

402.7 (1) the development, implementation, and monitoring of a comprehensive protocol of
402.8 care that is developed in conjunction with the parent or guardian of a medically complex
402.9 or technologically dependent child and that specifies the medical, nursing, psychosocial,
402.10 and developmental therapies required by the medically complex or technologically dependent
402.11 child; and

402.12 (2) the caregiver training needs of the child's parent or guardian.

402.13 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

402.14 Subd. 4. **Licensee.** "Licensee" means an owner of a prescribed pediatric extended care
402.15 (PPEC) center licensed under this chapter.

402.16 Subd. 5. **Medically complex or technologically dependent child.** "Medically complex
402.17 or technologically dependent child" means a child under 21 years of age who, because of
402.18 a medical condition, requires continuous therapeutic interventions or skilled nursing
402.19 supervision which must be prescribed by a licensed physician and administered by, or under
402.20 the direct supervision of, a licensed registered nurse.

402.21 Subd. 6. **Owner.** "Owner" means an individual whose ownership interest provides
402.22 sufficient authority or control to affect or change decisions regarding the operation of the
402.23 PPEC center. An owner includes a sole proprietor, a general partner, or any other individual
402.24 whose ownership interest has the ability to affect the management and direction of the PPEC
402.25 center's policies.

402.26 Subd. 7. **Prescribed pediatric extended care center, PPEC center, or center.**
402.27 "Prescribed pediatric extended care center," "PPEC center," or "center" means any facility
402.28 that provides nonresidential basic services to three or more medically complex or
402.29 technologically dependent children who require such services and who are not related to
402.30 the owner by blood, marriage, or adoption.

403.1 Subd. 8. **Supportive services or contracted services.** "Supportive services or contracted
403.2 services" include but are not limited to speech therapy, occupational therapy, physical
403.3 therapy, social work services, developmental services, child life services, and psychology
403.4 services.

403.5 Sec. 75. [144H.02] LICENSURE REQUIRED.

403.6 A person may not own or operate a prescribed pediatric extended care center in this state
403.7 unless the person holds a temporary or current license issued under this chapter. A separate
403.8 license must be obtained for each PPEC center maintained on separate premises, even if
403.9 the same management operates the PPEC centers. Separate licenses are not required for
403.10 separate buildings on the same grounds. A center shall not be operated on the same grounds
403.11 as a child care center licensed under Minnesota Rules, chapter 9503.

403.12 Sec. 76. [144H.03] EXEMPTIONS.

403.13 This chapter does not apply to:

403.14 (1) a facility operated by the United States government or a federal agency; or

403.15 (2) a health care facility licensed under chapter 144 or 144A.

403.16 Sec. 77. [144H.04] LICENSE APPLICATION AND RENEWAL.

403.17 Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a
403.18 completed application for licensure to the commissioner, in a form and manner determined
403.19 by the commissioner. The applicant must also submit the application fee, in the amount
403.20 specified in section 144H.05, subdivision 1. Effective January 1, 2018, the commissioner
403.21 shall issue a license for a PPEC center if the commissioner determines that the applicant
403.22 and center meet the requirements of this chapter and rules that apply to PPEC centers. A
403.23 license issued under this subdivision is valid for two years.

403.24 Subd. 2. **License renewal.** A license issued under subdivision 1 may be renewed for a
403.25 period of two years if the licensee:

403.26 (1) submits an application for renewal in a form and manner determined by the
403.27 commissioner, at least 30 days before the license expires. An application for renewal
403.28 submitted after the renewal deadline date must be accompanied by a late fee in the amount
403.29 specified in section 144H.05, subdivision 3;

403.30 (2) submits the renewal fee in the amount specified in section 144H.05, subdivision 2;

404.1 (3) demonstrates that the licensee has provided basic services at the PPEC center within
 404.2 the past two years;

404.3 (4) provides evidence that the applicant meets the requirements for licensure; and

404.4 (5) provides other information required by the commissioner.

404.5 Subd. 3. **License not transferable.** A PPEC center license issued under this section is
 404.6 not transferable to another party. Before acquiring ownership of a PPEC center, a prospective
 404.7 applicant must apply to the commissioner for a new license.

404.8 Sec. 78. **[144H.05] FEES.**

404.9 Subdivision 1. **Initial application fee.** The initial application fee for PPEC center
 404.10 licensure is \$3,820.

404.11 Subd. 2. **License renewal.** The fee for renewal of a PPEC center license is \$1,800.

404.12 Subd. 3. **Late fee.** The fee for late submission of an application to renew a PPEC center
 404.13 license is \$25.

404.14 Subd. 4. **Change of ownership.** The fee for change of ownership of a PPEC center is
 404.15 \$4,200.

404.16 Subd. 5. **Nonrefundable; state government special revenue fund.** All fees collected
 404.17 under this chapter are nonrefundable and must be deposited in the state treasury and credited
 404.18 to the state government special revenue fund.

404.19 Sec. 79. **[144H.06] APPLICATION OF RULES FOR HOSPICE SERVICES AND**
 404.20 **RESIDENTIAL HOSPICE FACILITIES.**

404.21 Minnesota Rules, chapter 4664, shall apply to PPEC centers licensed under this chapter,
 404.22 except that the following parts, subparts, items, and subitems do not apply:

404.23 (1) Minnesota Rules, part 4664.0003, subparts 2, 6, 7, 11, 12, 13, 14, and 38;

404.24 (2) Minnesota Rules, part 4664.0008;

404.25 (3) Minnesota Rules, part 4664.0010, subparts 3; 4, items A, subitem (6), and B; and 8;

404.26 (4) Minnesota Rules, part 4664.0020, subpart 13;

404.27 (5) Minnesota Rules, part 4664.0370, subpart 1;

404.28 (6) Minnesota Rules, part 4664.0390, subpart 1, items A, C, and E;

404.29 (7) Minnesota Rules, part 4664.0420;

405.1 (8) Minnesota Rules, part 4664.0425, subparts 3, item A; 4; and 6;

405.2 (9) Minnesota Rules, part 4664.0430, subparts 3, 4, 5, 7, 8, 9, 10, 11, and 12;

405.3 (10) Minnesota Rules, part 4664.0490; and

405.4 (11) Minnesota Rules, part 4664.0520.

405.5 Sec. 80. **[144H.07] SERVICES; LIMITATIONS.**

405.6 Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex
405.7 or technologically dependent children, based on a protocol of care established for each child.

405.8 A PPEC center may provide services up to 14 hours a day and up to six days a week.

405.9 Subd. 2. **Limitations.** A PPEC center must comply with the following standards related
405.10 to services:

405.11 (1) a child is prohibited from attending a PPEC center for more than 14 hours within a
405.12 24-hour period;

405.13 (2) a PPEC center is prohibited from providing services other than those provided to
405.14 medically complex or technologically dependent children; and

405.15 (3) the maximum capacity for medically complex or technologically dependent children
405.16 at a center shall not exceed 45 children.

405.17 Sec. 81. **[144H.08] ADMINISTRATION AND MANAGEMENT.**

405.18 Subdivision 1. **Duties of owner.** (a) The owner of a PPEC center shall have full legal
405.19 authority and responsibility for the operation of the center. A PPEC center must be organized
405.20 according to a written table of organization, describing the lines of authority and
405.21 communication to the child care level. The organizational structure must be designed to
405.22 ensure an integrated continuum of services for the children served.

405.23 (b) The owner must designate one person as a center administrator, who is responsible
405.24 and accountable for overall management of the center.

405.25 Subd. 2. **Duties of administrator.** The center administrator is responsible and accountable
405.26 for overall management of the center. The administrator must:

405.27 (1) designate in writing a person to be responsible for the center when the administrator
405.28 is absent from the center for more than 24 hours;

405.29 (2) maintain the following written records, in a place and form and using a system that
405.30 allows for inspection of the records by the commissioner during normal business hours:

406.1 (i) a daily census record, which indicates the number of children currently receiving
406.2 services at the center;

406.3 (ii) a record of all accidents or unusual incidents involving any child or staff member
406.4 that caused, or had the potential to cause, injury or harm to a person at the center or to center
406.5 property;

406.6 (iii) copies of all current agreements with providers of supportive services or contracted
406.7 services;

406.8 (iv) copies of all current agreements with consultants employed by the center,
406.9 documentation of each consultant's visits, and written, dated reports; and

406.10 (v) a personnel record for each employee, which must include an application for
406.11 employment, references, employment history for the preceding five years, and copies of all
406.12 performance evaluations;

406.13 (3) develop and maintain a current job description for each employee;

406.14 (4) provide necessary qualified personnel and ancillary services to ensure the health,
406.15 safety, and proper care for each child; and

406.16 (5) develop and implement infection control policies that comply with rules adopted by
406.17 the commissioner regarding infection control.

406.18 **Sec. 82. [144H.09] ADMISSION, TRANSFER, AND DISCHARGE POLICIES;**
406.19 **CONSENT FORM.**

406.20 Subdivision 1. **Written policies.** A PPEC center must have written policies and
406.21 procedures governing the admission, transfer, and discharge of children.

406.22 Subd. 2. **Notice of discharge.** At least ten days prior to a child's discharge from a PPEC
406.23 center, the PPEC center shall provide notice of the discharge to the child's parent or guardian.

406.24 Subd. 3. **Consent form.** A parent or guardian must sign a consent form outlining the
406.25 purpose of a PPEC center, specifying family responsibilities, authorizing treatment and
406.26 services, providing appropriate liability releases, and specifying emergency disposition
406.27 plans, before the child's admission to the center. The center must provide the child's parents
406.28 or guardians with a copy of the consent form and must maintain the consent form in the
406.29 child's medical record.

407.1 Sec. 83. [144H.10] MEDICAL DIRECTOR.

407.2 A PPEC center must have a medical director who is a physician licensed in Minnesota
407.3 and certified by the American Board of Pediatrics.

407.4 Sec. 84. [144H.11] NURSING SERVICES.

407.5 Subdivision 1. Nursing director. A PPEC center must have a nursing director who is
407.6 a registered nurse licensed in Minnesota, holds a current certification in cardiopulmonary
407.7 resuscitation, and has at least four years of general pediatric nursing experience, at least
407.8 one year of which must have been spent caring for medically fragile infants or children in
407.9 a pediatric intensive care, neonatal intensive care, PPEC center, or home care setting during
407.10 the previous five years. The nursing director is responsible for the daily operation of the
407.11 PPEC center.

407.12 Subd. 2. Registered nurses. A registered nurse employed by a PPEC center must be a
407.13 registered nurse licensed in Minnesota, hold a current certification in cardiopulmonary
407.14 resuscitation, and have experience in the previous 24 months in being responsible for the
407.15 care of acutely ill or chronically ill children.

407.16 Subd. 3. Licensed practical nurses. A licensed practical nurse employed by a PPEC
407.17 center must be supervised by a registered nurse and must be a licensed practical nurse
407.18 licensed in Minnesota, have at least two years of experience in pediatrics, and hold a current
407.19 certification in cardiopulmonary resuscitation.

407.20 Subd. 4. Other direct care personnel. (a) Direct care personnel governed by this
407.21 subdivision include nursing assistants and individuals with training and experience in the
407.22 field of education, social services, or child care.

407.23 (b) All direct care personnel employed by a PPEC center must work under the supervision
407.24 of a registered nurse and are responsible for providing direct care to children at the center.
407.25 Direct care personnel must have extensive, documented education and skills training in
407.26 providing care to infants and toddlers, provide employment references documenting skill
407.27 in the care of infants and children, and hold a current certification in cardiopulmonary
407.28 resuscitation.

408.1 Sec. 85. **[144H.12] TOTAL STAFFING FOR NURSING SERVICES AND DIRECT**
408.2 **CARE PERSONNEL.**

408.3 A PPEC center must provide total staffing for nursing services and direct care personnel
408.4 at a ratio of one staff person for every three children at the center. The staffing ratio required
408.5 in this section is the minimum staffing permitted.

408.6 Sec. 86. **[144H.13] MEDICAL RECORD; PROTOCOL OF CARE.**

408.7 A medical record and an individualized nursing protocol of care must be developed for
408.8 each child admitted to a PPEC center, must be maintained for each child, and must be signed
408.9 by authorized personnel.

408.10 Sec. 87. **[144H.14] QUALITY ASSURANCE PROGRAM.**

408.11 A PPEC center must have a quality assurance program, in which quarterly reviews are
408.12 conducted of the PPEC center's medical records and protocols of care for at least half of
408.13 the children served by the PPEC center. The quarterly review sample must be randomly
408.14 selected so each child at the center has an equal opportunity to be included in the review.
408.15 The committee conducting quality assurance reviews must include the medical director,
408.16 administrator, nursing director, and three other committee members determined by the PPEC
408.17 center.

408.18 Sec. 88. **[144H.15] INSPECTIONS.**

408.19 (a) The commissioner may inspect a PPEC center, including records held at the center,
408.20 at reasonable times as necessary to ensure compliance with this chapter and the rules that
408.21 apply to PPEC centers. During an inspection, a center must provide the commissioner with
408.22 access to all center records.

408.23 (b) The commissioner must inspect a PPEC center before issuing or renewing a license
408.24 under this chapter.

408.25 Sec. 89. **[144H.16] COMPLIANCE WITH OTHER LAWS.**

408.26 Subdivision 1. **Reporting of maltreatment of minors.** A PPEC center must develop
408.27 policies and procedures for reporting suspected child maltreatment that fulfill the
408.28 requirements of section 626.556. The policies and procedures must include the telephone
408.29 numbers of the local county child protection agency for reporting suspected maltreatment.
408.30 The policies and procedures specified in this subdivision must be provided to the parents

409.1 or guardians of all children at the time of admission to the PPEC center and must be available
409.2 upon request.

409.3 Subd. 2. **Crib safety requirements.** A PPEC center must comply with the crib safety
409.4 requirements in section 245A.146, to the extent they are applicable.

409.5 Sec. 90. **[144H.17] DENIAL, SUSPENSION, REVOCATION, REFUSAL TO RENEW**
409.6 **A LICENSE.**

409.7 (a) The commissioner may deny, suspend, revoke, or refuse to renew a license issued
409.8 under this chapter for:

409.9 (1) a violation of this chapter or rules adopted that apply to PPEC centers; or

409.10 (2) an intentional or negligent act by an employee or contractor at the center that
409.11 detrimentally affects the health or safety of children at the PPEC center.

409.12 (b) Prior to any suspension, revocation, or refusal to renew a license, a licensee shall be
409.13 entitled to a hearing and review as provided in sections 14.57 to 14.69.

409.14 Sec. 91. **[144H.18] FINES; CORRECTIVE ACTION PLANS.**

409.15 Subdivision 1. **Corrective action plans.** If the commissioner determines that a PPEC
409.16 center is not in compliance with this chapter or rules that apply to PPEC centers, the
409.17 commissioner may require the center to submit a corrective action plan that demonstrates
409.18 a good-faith effort to remedy each violation by a specific date, subject to approval by the
409.19 commissioner.

409.20 Subd. 2. **Fines.** The commissioner may issue a fine to a PPEC center, employee, or
409.21 contractor if the commissioner determines the center, employee, or contractor violated this
409.22 chapter or rules that apply to PPEC centers. The fine amount shall not exceed an amount
409.23 for each violation and an aggregate amount established by the commissioner. The failure
409.24 to correct a violation by the date set by the commissioner, or a failure to comply with an
409.25 approved corrective action plan, constitutes a separate violation for each day the failure
409.26 continues, unless the commissioner approves an extension to a specific date. In determining
409.27 if a fine is to be imposed and establishing the amount of the fine, the commissioner shall
409.28 consider:

409.29 (1) the gravity of the violation, including the probability that death or serious physical
409.30 or emotional harm to a child will result or has resulted, the severity of the actual or potential
409.31 harm, and the extent to which the applicable laws were violated;

410.1 (2) actions taken by the owner or administrator to correct violations;

410.2 (3) any previous violations; and

410.3 (4) the financial benefit to the PPEC center of committing or continuing the violation.

410.4 Subd. 3. **Fines for violations of other statutes.** The commissioner shall impose a fine
 410.5 of \$250 on a PPEC center, employee, or contractor for each violation by that PPEC center,
 410.6 employee, or contractor of section 144H.16, subdivision 2, or 626.556.

410.7 Sec. 92. **[144H.19] CLOSING A PPEC CENTER.**

410.8 When a PPEC center voluntarily closes, it must, at least 30 days before closure, inform
 410.9 each child's parents or guardians of the closure and when the closure will occur.

410.10 Sec. 93. **[144H.20] PHYSICAL ENVIRONMENT.**

410.11 Subdivision 1. **General requirements.** A PPEC center shall conform with or exceed
 410.12 the physical environment requirements in this section and the physical environment
 410.13 requirements for day care facilities in Minnesota Rules, part 9502.0425. If the physical
 410.14 environment requirements in this section differ from the physical environment requirements
 410.15 for day care facilities in Minnesota Rules, part 9502.0425, the requirements in this section
 410.16 shall prevail. A PPEC center must have sufficient indoor and outdoor space to accommodate
 410.17 at least six medically complex or technologically dependent children.

410.18 Subd. 2. **Specific requirements.** (a) The entrance to a PPEC center must be barrier-free,
 410.19 have a wheelchair ramp, provide for traffic flow with a driveway area for entering and
 410.20 exiting, and have storage space for supplies from home.

410.21 (b) A PPEC center must have a treatment room with a medication preparation area. The
 410.22 medication preparation area must contain a work counter, refrigerator, sink with hot and
 410.23 cold running water, and locked storage for biologicals and prescription drugs.

410.24 (c) A PPEC center must develop isolation procedures to prevent cross-infections and
 410.25 must have an isolation room with at least one glass area for observation of a child in the
 410.26 isolation room. The isolation room must be at least 100 square feet in size.

410.27 (d) A PPEC center must have:

410.28 (1) an outdoor play space adjacent to the center of at least 35 square feet per child in
 410.29 attendance at the center, for regular use; or

410.30 (2) a park, playground, or play space within 1,500 feet of the center.

411.1 (e) A PPEC center must have at least 50 square feet of usable indoor space per child in
411.2 attendance at the center.

411.3 (f) Notwithstanding the Minnesota State Building Code and the Minnesota State Fire
411.4 Code, a new construction PPEC center or an existing building converted into a PPEC center
411.5 must meet the requirements of the International Building Code in Minnesota Rules, chapter
411.6 1305, for:

411.7 (1) Group R, Division 4 occupancy, if serving 12 or fewer children; or

411.8 (2) Group E, Division 4 occupancy or Group I, Division 4 occupancy, if serving 13 or
411.9 more children.

411.10 Sec. 94. Minnesota Statutes 2016, section 145.4131, subdivision 1, is amended to read:

411.11 Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare
411.12 a reporting form for use by physicians or facilities performing abortions. A copy of this
411.13 section shall be attached to the form. A physician or facility performing an abortion shall
411.14 obtain a form from the commissioner.

411.15 (b) The form shall require the following information:

411.16 (1) the number of abortions performed by the physician in the previous calendar year,
411.17 reported by month;

411.18 (2) the method used for each abortion;

411.19 (3) the approximate gestational age expressed in one of the following increments:

411.20 (i) less than nine weeks;

411.21 (ii) nine to ten weeks;

411.22 (iii) 11 to 12 weeks;

411.23 (iv) 13 to 15 weeks;

411.24 (v) 16 to 20 weeks;

411.25 (vi) 21 to 24 weeks;

411.26 (vii) 25 to 30 weeks;

411.27 (viii) 31 to 36 weeks; or

411.28 (ix) 37 weeks to term;

411.29 (4) the age of the woman at the time the abortion was performed;

- 412.1 (5) the specific reason for the abortion, including, but not limited to, the following:
- 412.2 (i) the pregnancy was a result of rape;
- 412.3 (ii) the pregnancy was a result of incest;
- 412.4 (iii) economic reasons;
- 412.5 (iv) the woman does not want children at this time;
- 412.6 (v) the woman's emotional health is at stake;
- 412.7 (vi) the woman's physical health is at stake;
- 412.8 (vii) the woman will suffer substantial and irreversible impairment of a major bodily
- 412.9 function if the pregnancy continues;
- 412.10 (viii) the pregnancy resulted in fetal anomalies; or
- 412.11 (ix) unknown or the woman refused to answer;
- 412.12 (6) the number of prior induced abortions;
- 412.13 (7) the number of prior spontaneous abortions;
- 412.14 (8) whether the abortion was paid for by:
- 412.15 (i) private coverage;
- 412.16 (ii) public assistance health coverage; or
- 412.17 (iii) self-pay;
- 412.18 (9) whether coverage was under:
- 412.19 (i) a fee-for-service plan;
- 412.20 (ii) a capitated private plan; or
- 412.21 (iii) other;
- 412.22 (10) complications, if any, for each abortion and for the aftermath of each abortion.
- 412.23 Space for a description of any complications shall be available on the form;
- 412.24 (11) the medical specialty of the physician performing the abortion; ~~and~~
- 412.25 (12) if the abortion was performed via telemedicine, the facility code for the patient and
- 412.26 the facility code for the physician; and
- 412.27 ~~(12)~~ (13) whether the abortion resulted in a born alive infant, as defined in section
- 412.28 145.423, subdivision 4, and:

- 413.1 (i) any medical actions taken to preserve the life of the born alive infant;
- 413.2 (ii) whether the born alive infant survived; and
- 413.3 (iii) the status of the born alive infant, should the infant survive, if known.

413.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

413.5 Sec. 95. Minnesota Statutes 2016, section 145.4716, subdivision 2, is amended to read:

413.6 Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible
413.7 for the following:

413.8 (1) developing and providing comprehensive training on sexual exploitation of youth
413.9 for social service professionals, medical professionals, public health workers, and criminal
413.10 justice professionals;

413.11 (2) collecting, organizing, maintaining, and disseminating information on sexual
413.12 exploitation and services across the state, including maintaining a list of resources on the
413.13 Department of Health Web site;

413.14 (3) monitoring and applying for federal funding for antitrafficking efforts that may
413.15 benefit victims in the state;

413.16 (4) managing grant programs established under sections 145.4716 to 145.4718, ~~and~~
413.17 609.3241, paragraph (c), clause (3); and 609.5315, subdivision 5c, clause (3);

413.18 (5) managing the request for proposals for grants for comprehensive services, including
413.19 trauma-informed, culturally specific services;

413.20 (6) identifying best practices in serving sexually exploited youth, as defined in section
413.21 260C.007, subdivision 31;

413.22 (7) providing oversight of and technical support to regional navigators pursuant to section
413.23 145.4717;

413.24 (8) conducting a comprehensive evaluation of the statewide program for safe harbor of
413.25 sexually exploited youth; and

413.26 (9) developing a policy consistent with the requirements of chapter 13 for sharing data
413.27 related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among
413.28 regional navigators and community-based advocates.

414.1 Sec. 96. Minnesota Statutes 2016, section 145.928, subdivision 13, is amended to read:

414.2 Subd. 13. **Reports.** (a) The commissioner shall submit a biennial report to the legislature
414.3 on the local community projects, tribal government, and community health board prevention
414.4 activities funded under this section. These reports must include information on grant
414.5 recipients, activities that were conducted using grant funds, evaluation data, and outcome
414.6 measures, if available. These reports are due by January 15 of every other year, beginning
414.7 in the year 2003.

414.8 (b) The commissioner shall release an annual report to the public and submit an the
414.9 annual report to the chairs and ranking minority members of the house of representatives
414.10 and senate committees with jurisdiction over public health on grants made under subdivision
414.11 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide
414.12 specific information on the amount of each grant awarded to each agency or organization,
414.13 an itemized list submitted to the commissioner by each agency or organization awarded a
414.14 grant specifying all uses of grant funds and the amount expended for each use, the population
414.15 served by each agency or organization, outcomes of the programs funded by each grant,
414.16 and the amount of the appropriation retained by the commissioner for administrative and
414.17 associated expenses. The commissioner shall issue a report each January 15 for the previous
414.18 fiscal year beginning January 15, 2016.

414.19 Sec. 97. Minnesota Statutes 2016, section 145.986, subdivision 1a, is amended to read:

414.20 Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner
414.21 of health shall award competitive grants to community health boards and tribal governments
414.22 to convene, coordinate, and implement evidence-based strategies targeted at reducing the
414.23 percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.
414.24 Grants shall be awarded to all community health boards and tribal governments whose
414.25 proposals demonstrate the ability to implement programs designed to achieve the purposes
414.26 in subdivision 1 and other requirements of this section.

414.27 (b) Grantee activities shall:

414.28 (1) be based on scientific evidence;

414.29 (2) be based on community input;

414.30 (3) address behavior change at the individual, community, and systems levels;

414.31 (4) occur in community, school, work site, and health care settings;

415.1 (5) be focused on policy, systems, and environmental changes that support healthy
415.2 behaviors; and

415.3 (6) address the health disparities and inequities that exist in the grantee's community.

415.4 (c) To receive a grant under this section, community health boards and tribal governments
415.5 must submit proposals to the commissioner. A local match of ten percent of the total funding
415.6 allocation is required. This local match may include funds donated by community partners.

415.7 (d) In order to receive a grant, community health boards and tribal governments must
415.8 submit a health improvement plan to the commissioner of health for approval. The
415.9 commissioner may require the plan to identify a community leadership team, community
415.10 partners, and a community action plan that includes an assessment of area strengths and
415.11 needs, proposed action strategies, technical assistance needs, and a staffing plan.

415.12 (e) The grant recipient must implement the health improvement plan, evaluate the
415.13 effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

415.14 (f) Grant recipients shall report their activities and their progress toward the outcomes
415.15 established under subdivision 2 to the commissioner in a format and at a time specified by
415.16 the commissioner.

415.17 (g) All grant recipients shall be held accountable for making progress toward the
415.18 measurable outcomes established in subdivision 2. The commissioner shall require a
415.19 corrective action plan and may reduce the funding level of grant recipients that do not make
415.20 adequate progress toward the measurable outcomes.

415.21 (h) Beginning November 1, 2015, the commissioner shall offer grant recipients the
415.22 option of using a grant awarded under this subdivision to implement health improvement
415.23 strategies that improve the health status, delay the expression of dementia, or slow the
415.24 progression of dementia, for a targeted population at risk for dementia and shall award at
415.25 least two of the grants awarded on November 1, 2015, for these purposes. The grants must
415.26 meet all other requirements of this section. The commissioner shall coordinate grant planning
415.27 activities with the commissioner of human services, the Minnesota Board on Aging, and
415.28 community-based organizations with a focus on dementia. Each grant must include selected
415.29 outcomes and evaluation measures related to the incidence or progression of dementia
415.30 among the targeted population using the procedure described in subdivision 2.

415.31 (i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of
415.32 using a grant awarded under this subdivision to confront the opioid addiction and overdose
415.33 epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for

416.1 these purposes. The grants awarded under this paragraph must meet all other requirements
416.2 of this section. The commissioner shall coordinate grant planning activities with the
416.3 commissioner of human services. Each grant shall include selected outcomes and evaluation
416.4 measures related to addressing the opioid epidemic.

416.5 Sec. 98. Minnesota Statutes 2016, section 146B.02, subdivision 2, is amended to read:

416.6 Subd. 2. **Requirements and term of license.** (a) Each application for an initial mobile
416.7 or fixed-site establishment license and for renewal must be submitted to the commissioner
416.8 on a form provided by the commissioner accompanied with the applicable fee required
416.9 under section 146B.10. The application must contain:

416.10 (1) the name(s) of the owner(s) and operator(s) of the establishment;

416.11 (2) the location of the establishment;

416.12 (3) verification of compliance with all applicable local and state codes;

416.13 (4) a description of the general nature of the business; and

416.14 (5) any other relevant information deemed necessary by the commissioner.

416.15 (b) If the information submitted is complete and complies with the requirements of this
416.16 chapter, the commissioner shall issue a provisional establishment license. The provisional
416.17 license is effective until the commissioner determines, after inspection, that the applicant
416.18 has met the requirements of this chapter. Upon approval, the commissioner shall issue a
416.19 body art establishment license effective for three years.

416.20 (c) An establishment license must be renewed every two years.

416.21 Sec. 99. Minnesota Statutes 2016, section 146B.02, subdivision 3, is amended to read:

416.22 Subd. 3. **Inspection.** (a) ~~Within the period of the provisional establishment license, and~~
416.23 The commissioner must inspect an establishment issued a provisional license within one
416.24 year of the date the license was issued. Thereafter at least one time during each ~~three-year~~
416.25 two-year licensure period, the commissioner shall conduct an inspection of the body art
416.26 establishment and a review of any records necessary to ensure that the standards required
416.27 under this chapter are met.

416.28 (b) The commissioner shall have the authority to enter a premises to make an inspection.
416.29 Refusal to permit an inspection constitutes valid grounds for licensure denial or revocation.

416.30 (c) If the establishment seeking licensure is new construction or if a licensed establishment
416.31 is remodeling, the establishment must meet all local building and zoning codes.

417.1 Sec. 100. Minnesota Statutes 2016, section 146B.02, subdivision 5, is amended to read:

417.2 Subd. 5. **Transfer of ownership, relocation, and display of license.** (a) A body art
417.3 establishment license must be issued to a specific person and location and is not transferable.
417.4 A license must be prominently displayed in a public area of the establishment.

417.5 (b) An owner who has purchased a body art establishment licensed under the previous
417.6 owner must submit an application to license the establishment within two weeks of the date
417.7 of sale. Notwithstanding subdivision 1, the new owner may continue to operate for 60 days
417.8 after the sale while waiting for a new license to be issued.

417.9 (c) An owner of a licensed body art establishment who is relocating the establishment
417.10 must submit an application for the new location. The owner may request that the new
417.11 application become effective at a specified date in the future. If the relocation is not
417.12 accomplished by the date expected, and the license at the existing location expires, the
417.13 owner may apply for a temporary event permit to continue to operate at the old location.
417.14 The owner may apply for no more than four temporary event permits to continue operating
417.15 at the old location.

417.16 Sec. 101. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision
417.17 to read:

417.18 Subd. 7a. **Supervisors.** (a) Only a technician who has been licensed as a body artist for
417.19 at least two years in Minnesota or in a jurisdiction with which Minnesota has reciprocity
417.20 may supervise a temporary technician.

417.21 (b) Any technician who agrees to supervise more than two temporary technicians during
417.22 the same time period must provide to the commissioner a supervisory plan that describes
417.23 how the technician will provide supervision to each temporary technician in accordance
417.24 with section 146B.01, subdivision 28.

417.25 (c) The commissioner may refuse to approve as a supervisor a technician who has been
417.26 disciplined in Minnesota or in another jurisdiction after considering the criteria described
417.27 in subdivision 10, paragraph (b).

417.28 Sec. 102. Minnesota Statutes 2016, section 146B.02, subdivision 8, is amended to read:

417.29 Subd. 8. **Temporary events event permit.** (a) ~~An owner or operator of a~~ applicant for
417.30 a permit to hold a temporary body art establishment event shall submit an application ~~for a~~
417.31 ~~temporary events permit~~ to the commissioner. The application must be received at least 14
417.32 days before the start of the event. The application must include the specific days and hours

418.1 of operation. ~~The owner or operator~~ An applicant issued a temporary event permit shall
418.2 comply with the requirements of this chapter.

418.3 (b) Applications received less than 14 days prior to the start of the event may be processed
418.4 if the commissioner determines it is possible to conduct ~~the~~ all required work, including an
418.5 inspection.

418.6 (c) The temporary ~~events~~ event permit must be prominently displayed in a public area
418.7 at the location.

418.8 (d) The temporary ~~events~~ event permit, if approved, is valid for the specified dates and
418.9 hours listed on the application. No temporary events permit shall be issued for longer than
418.10 a 21-day period, and may not be extended.

418.11 (e) No individual who does not hold a current body art establishment license may be
418.12 issued a temporary event permit more than four times within the same calendar year.

418.13 (f) No individual who has been disciplined for a serious violation of this chapter within
418.14 three years preceding the intended start date of a temporary event may be issued a license
418.15 for a temporary event. Violations that preclude issuance of a temporary event permit include
418.16 unlicensed practice; practice in an unlicensed location; any of the conditions listed in section
418.17 146B.05, clauses (1) to (8), (12), or (13); 146B.08, subdivision 3, clauses (4), (5), and (10)
418.18 to (12); or any other violation that places the health or safety of a client at risk.

418.19 Sec. 103. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision
418.20 to read:

418.21 **Subd. 10. Licensure precluded.** (a) The commissioner may choose to deny a body art
418.22 establishment license to an applicant who has been disciplined for a serious violation under
418.23 this chapter. Violations that constitute grounds for denial of license are any of the conditions
418.24 listed in section 146B.05, subdivision 1, clauses (1) to (8), (12), or (13); 146B.08, subdivision
418.25 3, clauses (4), (5), or (10) to (12); or any other violation that places the health or safety of
418.26 a client at risk.

418.27 (b) In considering whether to grant a license to an applicant who has been disciplined
418.28 for a violation described in this subdivision, the commissioner shall consider evidence of
418.29 rehabilitation, including the nature and seriousness of the violation, circumstances relative
418.30 to the violation, the length of time elapsed since the violation, and evidence that demonstrates
418.31 that the applicant has maintained safe, ethical, and responsible body art practice since the
418.32 time of the most recent violation.

419.1 Sec. 104. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision
419.2 to read:

419.3 Subd. 11. **Penalties.** Any person who violates the provisions of subdivision 1 or who
419.4 performs body art in an unlicensed location is guilty of a gross misdemeanor.

419.5 Sec. 105. Minnesota Statutes 2016, section 146B.03, subdivision 6, is amended to read:

419.6 Subd. 6. **Licensure term; renewal.** (a) A technician's license is valid for two years from
419.7 the date of issuance and may be renewed upon payment of the renewal fee established under
419.8 section 146B.10.

419.9 (b) At renewal, a licensee must submit proof of continuing education approved by the
419.10 commissioner in the areas identified in subdivision 4.

419.11 (c) The commissioner shall notify the technician of the pending expiration of a technician
419.12 license at least 60 days prior to license expiration.

419.13 (d) A technician previously licensed in Minnesota whose license has lapsed for less than
419.14 six years may apply to renew. A technician previously licensed in Minnesota whose license
419.15 has lapsed for less than ten years and who was licensed in another jurisdiction or jurisdictions
419.16 during the entire time of lapse may apply to renew, but must submit proof of licensure in
419.17 good standing in all other jurisdictions in which the technician was licensed as a body artist
419.18 during the time of lapse. A technician previously licensed in Minnesota whose license has
419.19 lapsed for more than six years and who was not continuously licensed in another jurisdiction
419.20 during the period of Minnesota lapse must reapply for licensure under subdivision 4.

419.21 Sec. 106. Minnesota Statutes 2016, section 146B.03, subdivision 7, as amended by Laws
419.22 2017, chapter 40, article 1, section 34, is amended to read:

419.23 Subd. 7. **Temporary licensure.** (a) The commissioner may issue a temporary license
419.24 to an applicant who submits to the commissioner on a form provided by the commissioner:

419.25 (1) proof that the applicant is over the age of 18;

419.26 (2) all fees required under section 146B.10; and

419.27 (3) a letter from a licensed technician who has agreed to provide the supervision to meet
419.28 the supervised experience requirement under subdivision 4.

419.29 (b) Upon completion of the required supervised experience, the temporary licensee shall
419.30 submit documentation of satisfactorily completing the requirements under subdivision 4,

420.1 and the applicable fee under section 146B.10. The commissioner shall issue a new license
420.2 in accordance with subdivision 4.

420.3 (c) A temporary license issued under this subdivision is valid for one year and may be
420.4 renewed ~~for one additional year~~ twice.

420.5 Sec. 107. Minnesota Statutes 2016, section 146B.07, subdivision 2, is amended to read:

420.6 Subd. 2. **Parent or legal guardian consent; prohibitions.** (a) A technician may perform
420.7 body piercings on an individual under the age of 18 if:

420.8 (1) the individual's parent or legal guardian is present;

420.9 (2) the individual's parent or legal guardian provides personal identification by using
420.10 one of the methods described in subdivision 1, paragraph (a), clauses (1) to (5), and provides
420.11 documentation that reasonably establishes that the individual is the parent or legal guardian
420.12 of the individual who is seeking the body piercing;

420.13 (3) the individual seeking the body piercing provides proof of identification by using
420.14 one of the methods described in subdivision 1, paragraph (a), clauses (1) to (5), a current
420.15 student identification, or another official source that includes the name and a photograph
420.16 of the individual;

420.17 (4) a consent form and the authorization form under subdivision 1, paragraph (b) is
420.18 signed by the parent or legal guardian in the presence of the technician; and

420.19 (5) the piercing is not prohibited under paragraph (c).

420.20 (b) ~~No technician shall tattoo any~~ Tattooing an individual under the age of 18 is a gross
420.21 misdemeanor, regardless of parental or guardian consent.

420.22 (c) No nipple or genital piercing, branding, scarification, suspension, subdermal
420.23 implantation, microdermal, or tongue bifurcation shall be performed by any technician on
420.24 any individual under the age of 18 regardless of parental or guardian consent.

420.25 (d) No technician shall perform body art procedures on any individual who appears to
420.26 be under the influence of alcohol, controlled substances as defined in section 152.01,
420.27 subdivision 4, or hazardous substances as defined in rules adopted under chapter 182.

420.28 (e) No technician shall perform body art procedures while under the influence of alcohol,
420.29 controlled substances as defined under section 152.01, subdivision 4, or hazardous substances
420.30 as defined in the rules adopted under chapter 182.

420.31 (f) No technician shall administer anesthetic injections or other medications.

421.1 Sec. 108. Minnesota Statutes 2016, section 146B.10, subdivision 1, is amended to read:

421.2 Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure and biennial
421.3 licensure renewal is ~~\$100~~ \$420.

421.4 (b) The fee for temporary technician licensure is ~~\$100~~ \$240.

421.5 (c) The fee for the temporary guest artist license is ~~\$50~~ \$140.

421.6 (d) The fee for a dual body art technician license is ~~\$100~~ \$420.

421.7 (e) The fee for a provisional establishment license is ~~\$1,000~~ \$1,500.

421.8 (f) The fee for an initial establishment license and the ~~three-year~~ two-year license renewal
421.9 period required in section 146B.02, subdivision 2, paragraph (b), is ~~\$1,000~~ \$1,500.

421.10 (g) The fee for a temporary body art establishment event permit is ~~\$75~~ \$200.

421.11 (h) The commissioner shall prorate the initial two-year technician license fee ~~and the~~
421.12 ~~initial three-year body art establishment license fee~~ based on the number of months in the
421.13 initial licensure period. The commissioner shall prorate the first renewal fee for the
421.14 establishment license based on the number of months from issuance of the provisional
421.15 license to the first renewal.

421.16 (i) The fee for verification of licensure to other states is \$25.

421.17 (j) The fee to reissue a provisional establishment license that relocates prior to inspection
421.18 and removal of provisional status is \$350. The expiration date of the provisional license
421.19 does not change.

421.20 (k) The fee to change an establishment name or establishment type, such as tattoo,
421.21 piercing, or dual, is \$50.

421.22 Sec. 109. Minnesota Statutes 2016, section 146B.10, subdivision 2, is amended to read:

421.23 Subd. 2. **Penalty for Late renewals renewal fee.** (a) The ~~penalty~~ fee for late submission
421.24 ~~for~~ of a technician renewal applications application is ~~\$75~~ \$150.

421.25 (b) The fee for late submission of an establishment renewal application is \$300.

421.26 Sec. 110. Minnesota Statutes 2016, section 146B.10, is amended by adding a subdivision
421.27 to read:

421.28 Subd. 2a. **Technical violation fee for practice after lapse.** (a) The technical violation
421.29 fee for practicing body art after a body art license has expired and before it is renewed is

422.1 \$200 for any part of the first month, plus \$200 for any part of any subsequent month up to
422.2 one year. Continued practice or operation after one year becomes a disciplinary violation.

422.3 (b) The technical violation fee for practicing body art after a temporary body art license
422.4 has expired and before it is renewed is \$100 for any part of the first month, plus \$100 for
422.5 any part of any subsequent month up to six months. Continued practice or operation after
422.6 six months becomes a disciplinary violation.

422.7 (c) The technical violation fee for operating a body art establishment after the license
422.8 has expired and before it is renewed is \$300 for any part of the first month, plus \$300 for
422.9 any part of any subsequent month up to six months. Continued practice or operation after
422.10 six months becomes a disciplinary violation.

422.11 Sec. 111. Minnesota Statutes 2016, section 148.514, subdivision 1, is amended to read:

422.12 Subdivision 1. **General licensure procedures.** An applicant for licensure must:

422.13 (1) submit an application as required under section 148.519, subdivision 1; ~~and~~

422.14 (2) submit all fees required under section 148.5194-; and

422.15 (3) consent to a fingerprint-based background check as required under section 148.519.

422.16 Sec. 112. Minnesota Statutes 2016, section 148.519, subdivision 1, is amended to read:

422.17 Subdivision 1. **Applications for licensure.** (a) An applicant for licensure must:

422.18 (1) submit a completed application for licensure on forms provided by the commissioner.
422.19 The application must include the applicant's name, certification number under chapter 153A,
422.20 if applicable, business address and telephone number, or home address and telephone number
422.21 if the applicant practices speech-language pathology or audiology out of the home, and a
422.22 description of the applicant's education, training, and experience, including previous work
422.23 history for the five years immediately preceding the date of application. The commissioner
422.24 may ask the applicant to provide additional information necessary to clarify information
422.25 submitted in the application; and

422.26 (2) submit documentation of the certificate of clinical competence issued by the American
422.27 Speech-Language-Hearing Association, board certification by the American Board of
422.28 Audiology, or satisfy the following requirements:

422.29 (i) submit a transcript showing the completion of a master's or doctoral degree or its
422.30 equivalent meeting the requirements of section 148.515, subdivision 2;

422.31 (ii) submit documentation of the required hours of supervised clinical training;

423.1 (iii) submit documentation of the postgraduate clinical or doctoral clinical experience
 423.2 meeting the requirements of section 148.515, subdivision 4; and

423.3 (iv) submit documentation of receiving a qualifying score on an examination meeting
 423.4 the requirements of section 148.515, subdivision 6.

423.5 (b) In addition, an applicant must:

423.6 (1) sign a statement that the information in the application is true and correct to the best
 423.7 of the applicant's knowledge and belief;

423.8 (2) submit with the application all fees required by section 148.5194; ~~and~~

423.9 (3) sign a waiver authorizing the commissioner to obtain access to the applicant's records
 423.10 in this or any other state in which the applicant has engaged in the practice of speech-language
 423.11 pathology or audiology; and

423.12 (4) consent to a fingerprint-based criminal history background check as required under
 423.13 section 144.0572, pay all required fees, and cooperate with all requests for information. An
 423.14 applicant must complete a new criminal history background check if more than one year
 423.15 has elapsed since the applicant last applied for a license.

423.16 Sec. 113. Minnesota Statutes 2016, section 148.519, subdivision 2, is amended to read:

423.17 Subd. 2. **Action on applications for licensure.** (a) The commissioner shall act on an
 423.18 application for licensure according to paragraphs (b) to ~~(d)~~ (e).

423.19 (b) The commissioner shall determine if the applicant meets the requirements for
 423.20 licensure. The commissioner or advisory council may investigate information provided by
 423.21 an applicant to determine whether the information is accurate and complete.

423.22 (c) The commissioner shall not issue a license to an applicant who refuses to consent to
 423.23 a background study within 90 days after submission of an application or fails to submit
 423.24 fingerprints to the Department of Human Services. Any fees paid by the applicant to the
 423.25 Department of Health shall be forfeited if the applicant refuses to consent to the background
 423.26 study.

423.27 ~~(e)~~ (d) The commissioner shall notify an applicant, via certified mail, of action taken on
 423.28 the application and of the grounds for denying licensure if licensure is denied.

423.29 ~~(d)~~ (e) An applicant denied licensure may make a written request to the commissioner,
 423.30 within 30 days of the date of notification to the applicant, for reconsideration of the denial.
 423.31 Individuals requesting reconsideration may submit information that the applicant wants
 423.32 considered in the reconsideration. After reconsideration of the commissioner's determination

424.1 to deny licensure, the commissioner shall determine whether the original determination
 424.2 should be affirmed or modified. An applicant may make only one request in any one biennial
 424.3 license period for reconsideration of the commissioner's determination to deny licensure.

424.4 Sec. 114. Minnesota Statutes 2016, section 148.5194, subdivision 2, is amended to read:

424.5 Subd. 2. **Speech-language pathologist biennial licensure fee fees.** (a) The fee for initial
 424.6 licensure ~~and biennial licensure, clinical fellowship licensure, temporary licensure, or~~
 424.7 ~~renewal~~ for a speech-language pathologist is ~~\$200~~ \$210.50.

424.8 (b) The fee for clinical fellowship licensure, doctoral externship, temporary license, or
 424.9 renewal for a speech-language pathologist is \$200.

424.10 Sec. 115. Minnesota Statutes 2016, section 148.5194, subdivision 3, is amended to read:

424.11 Subd. 3. **Biennial Licensure fee fees for dual licensure as a speech-language**
 424.12 **pathologist and audiologist.** (a) The fee for initial dual licensure and biennial licensure,
 424.13 clinical fellowship licensure, doctoral externship, temporary license, or renewal as a
 424.14 speech-language pathologist and audiologist is \$435 \$523.

424.15 (b) The fee for clinical fellowship licensure, doctoral externship, temporary license, or
 424.16 renewal for dual licensure as a speech-language pathologist and audiologist is \$510.

424.17 Sec. 116. Minnesota Statutes 2016, section 148.5194, subdivision 4, is amended to read:

424.18 Subd. 4. **Penalty fee for late renewals.** The penalty fee for late submission of a renewal
 424.19 application is ~~\$45~~ \$60.

424.20 Sec. 117. Minnesota Statutes 2016, section 148.5194, subdivision 7, is amended to read:

424.21 Subd. 7. **Audiologist biennial licensure fee.** (a) The licensure fee for initial applicants
 424.22 is \$523. The biennial licensure fee for audiologists for clinical fellowship, doctoral externship,
 424.23 temporary, ~~initial applicants,~~ and renewal ~~licensees~~ licenses is ~~\$435~~ \$510.

424.24 (b) ~~The audiologist fee is for practical examination costs greater than audiologist exam~~
 424.25 ~~fee receipts and for complaint investigation, enforcement action, and consumer information~~
 424.26 ~~and assistance expenditures related to hearing instrument dispensing.~~

425.1 Sec. 118. Minnesota Statutes 2016, section 148.5194, is amended by adding a subdivision
425.2 to read:

425.3 Subd. 7a. **Surcharge.** Speech-language pathologists who were licensed prior to January
425.4 1, 2018, shall pay a onetime surcharge of \$10.50 to renew when their license first expires
425.5 after January 1, 2020. Audiologists who were licensed before January 1, 2018, shall pay a
425.6 onetime surcharge of \$13 to renew when their license first expires after January 1, 2020.
425.7 The surcharge shall cover the commissioner's costs associated with criminal background
425.8 checks.

425.9 Sec. 119. Minnesota Statutes 2016, section 148.5195, subdivision 2, is amended to read:

425.10 Subd. 2. **Rights of applicants and licensees.** The rights of an applicant denied licensure
425.11 are stated in section 148.519, subdivision 2, paragraph ~~(d)~~ (e). A licensee shall not be
425.12 subjected to disciplinary action under this section without first having an opportunity for a
425.13 contested case hearing under chapter 14.

425.14 Sec. 120. Minnesota Statutes 2016, section 148.997, subdivision 1, is amended to read:

425.15 Subdivision 1. **Fees.** (a) The application fee is ~~\$130~~ \$185.

425.16 (b) The criminal background check fee is ~~\$6~~ \$15.

425.17 Sec. 121. Minnesota Statutes 2016, section 152.25, subdivision 1, is amended to read:

425.18 Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner
425.19 shall register two in-state manufacturers for the production of all medical cannabis within
425.20 the state ~~by December 1, 2014, unless the commissioner obtains an adequate supply of~~
425.21 ~~federally sourced medical cannabis by August 1, 2014.~~ The commissioner shall register
425.22 new manufacturers or reregister the existing manufacturers by December 1 every two years,
425.23 using the factors described in ~~paragraph (e)~~ this subdivision. The commissioner shall ~~continue~~
425.24 ~~to accept applications after December 1, 2014, if two manufacturers that meet the~~
425.25 ~~qualifications set forth in this subdivision do not apply before December 1, 2014 if one of~~
425.26 the manufacturers registered before December 1, 2014, ceases to be registered as a
425.27 manufacturer. The commissioner's determination that no manufacturer exists to fulfill the
425.28 duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County
425.29 District Court. Data submitted during the application process are private data on individuals
425.30 or nonpublic data as defined in section 13.02 until the manufacturer is registered under this
425.31 section. Data on a manufacturer that is registered are public data, unless the data are trade
425.32 secret or security information under section 13.37.

426.1 (b) As a condition for registration, a manufacturer must agree to:

426.2 (1) begin supplying medical cannabis to patients by July 1, 2015; and

426.3 (2) comply with all requirements under sections 152.22 to 152.37.

426.4 (c) The commissioner shall consider the following factors when determining which
426.5 manufacturer to register:

426.6 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
426.7 converting the medical cannabis into an acceptable delivery method under section 152.22,
426.8 subdivision 6;

426.9 (2) the qualifications of the manufacturer's employees;

426.10 (3) the long-term financial stability of the manufacturer;

426.11 (4) the ability to provide appropriate security measures on the premises of the
426.12 manufacturer;

426.13 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
426.14 production needs required by sections 152.22 to 152.37; and

426.15 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
426.16 qualifying medical condition.

426.17 (d) If an officer, director, or controlling person of the manufacturer pleads or is found
426.18 guilty of intentionally diverting medical cannabis to a person other than allowed by law
426.19 under section 152.33, subdivision 1, the commissioner may decide not to renew the
426.20 registration of the manufacturer, provided the violation occurred while the person was an
426.21 officer, director, or controlling person of the manufacturer.

426.22 ~~(d)~~ (e) The commissioner shall require each medical cannabis manufacturer to contract
426.23 with an independent laboratory to test medical cannabis produced by the manufacturer. The
426.24 commissioner shall approve the laboratory chosen by each manufacturer and require that
426.25 the laboratory report testing results to the manufacturer in a manner determined by the
426.26 commissioner.

426.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

426.28 Sec. 122. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision
426.29 to read:

426.30 **Subd. 1a. Revocation, nonrenewal, or denial of consent to transfer a medical cannabis**
426.31 **manufacturer registration.** If the commissioner intends to revoke, not renew, or deny

427.1 consent to transfer a registration issued under this section, the commissioner must first notify
427.2 in writing the manufacturer against whom the action is to be taken and provide the
427.3 manufacturer with an opportunity to request a hearing under the contested case provisions
427.4 of chapter 14. If the manufacturer does not request a hearing by notifying the commissioner
427.5 in writing within 20 days after receipt of the notice of proposed action, the commissioner
427.6 may proceed with the action without a hearing. For revocations, the registration of a
427.7 manufacturer is considered revoked on the date specified in the commissioner's written
427.8 notice of revocation.

427.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

427.10 Sec. 123. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision
427.11 to read:

427.12 Subd. 1b. **Temporary suspension proceedings.** The commissioner may institute
427.13 proceedings to temporarily suspend the registration of a medical cannabis manufacturer for
427.14 a period of up to 90 days by notifying the manufacturer in writing if any action by an
427.15 employee, agent, officer, director, or controlling person of the manufacturer:

427.16 (1) violates any of the requirements of sections 152.21 to 152.37 or the rules adopted
427.17 thereunder;

427.18 (2) permits, aids, or abets the commission of any violation of state law at the
427.19 manufacturer's location for cultivation, harvesting, manufacturing, packaging, and processing
427.20 or at any site for distribution of medical cannabis;

427.21 (3) performs any act contrary to the welfare of a registered patient or registered designated
427.22 caregiver; or

427.23 (4) obtains, or attempts to obtain, a registration by fraudulent means or misrepresentation.

427.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

427.25 Sec. 124. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision
427.26 to read:

427.27 Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's
427.28 registration under subdivision 1a or implementation of an enforcement action under
427.29 subdivision 1b that may affect the ability of a registered patient, registered designated
427.30 caregiver, or a registered patient's parent or legal guardian to obtain medical cannabis from
427.31 the manufacturer subject to the enforcement action, the commissioner shall notify in writing
427.32 each registered patient and the patient's registered designated caregiver or registered patient's

428.1 parent or legal guardian about the outcome of the proceeding and information regarding
428.2 alternative registered manufacturers. This notice must be provided two or more business
428.3 days prior to the effective date of the revocation, nonrenewal, or other enforcement action.

428.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

428.5 Sec. 125. Minnesota Statutes 2016, section 152.28, is amended by adding a subdivision
428.6 to read:

428.7 Subd. 3. **Advertising restrictions.** (a) A health care practitioner shall not publish or
428.8 cause to be published any advertisement that:

428.9 (1) contains false or misleading statements about medical cannabis or about the medical
428.10 cannabis registry program;

428.11 (2) uses colloquial terms to refer to medical cannabis, such as pot, weed, or grass;

428.12 (3) states or implies the health care practitioner is endorsed by the Department of Health
428.13 or by the medical cannabis registry program;

428.14 (4) includes images of cannabis in its plant or leaf form or of cannabis-smoking
428.15 paraphernalia; or

428.16 (5) contains medical symbols that could reasonably be confused with symbols of
428.17 established medical associations or groups.

428.18 (b) A health care practitioner found by the commissioner to have violated this subdivision
428.19 is prohibited from certifying that patients have a qualifying medical condition for purposes
428.20 of patient participation in the registry program. The commissioner's decision that a health
428.21 care practitioner has violated this subdivision is a final decision of the commissioner and
428.22 is not subject to the contested case procedures in chapter 14.

428.23 Sec. 126. Minnesota Statutes 2016, section 152.33, is amended by adding a subdivision
428.24 to read:

428.25 Subd. 1a. **Intentional diversion outside the state; penalties.** (a) In addition to any other
428.26 applicable penalty in law, the commissioner shall levy a fine of \$250,000 against a
428.27 manufacturer and may immediately initiate proceedings to revoke the manufacturer's
428.28 registration, using the procedure in section 152.25, if:

428.29 (1) an officer, director, or controlling person of the manufacturer pleads or is found
428.30 guilty under subdivision 1 of intentionally transferring medical cannabis, while the person

429.1 was an officer, director, or controlling person of the manufacturer, to a person other than
429.2 allowed by law; and

429.3 (2) in intentionally transferring medical cannabis to a person other than allowed by law,
429.4 the officer, director, or controlling person transported or directed the transport of medical
429.5 cannabis outside of Minnesota.

429.6 (b) All fines collected under this subdivision shall be deposited in the state government
429.7 special revenue fund.

429.8 **EFFECTIVE DATE.** This section is effective the day following final enactment, and
429.9 applies to crimes committed on or after that date.

429.10 Sec. 127. Minnesota Statutes 2016, section 153A.14, subdivision 1, is amended to read:

429.11 Subdivision 1. **Application for certificate.** An applicant must:

429.12 (1) be 21 years of age or older;

429.13 (2) apply to the commissioner for a certificate to dispense hearing instruments on
429.14 application forms provided by the commissioner;

429.15 (3) at a minimum, provide the applicant's name, Social Security number, business address
429.16 and phone number, employer, and information about the applicant's education, training,
429.17 and experience in testing human hearing and fitting hearing instruments;

429.18 (4) include with the application a statement that the statements in the application are
429.19 true and correct to the best of the applicant's knowledge and belief;

429.20 (5) include with the application a written and signed authorization that authorizes the
429.21 commissioner to make inquiries to appropriate regulatory agencies in this or any other state
429.22 where the applicant has sold hearing instruments;

429.23 (6) submit certification to the commissioner that the applicant's audiometric equipment
429.24 has been calibrated to meet current ANSI standards within 12 months of the date of the
429.25 application;

429.26 (7) submit evidence of continuing education credits, if required; ~~and~~

429.27 (8) submit all fees as required under section 153A.17; and

429.28 (9) consent to a fingerprint-based criminal history records check required under section
429.29 144.0572, pay all required fees, and cooperate with all requests for information. An applicant
429.30 must complete a new criminal background check if more than one year has elapsed since
429.31 the applicant last applied for a license.

430.1 Sec. 128. Minnesota Statutes 2016, section 153A.14, subdivision 2, is amended to read:

430.2 Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each
 430.3 dispenser of hearing instruments who applies under subdivision 1 if the commissioner
 430.4 determines that the applicant is in compliance with this chapter, has passed an examination
 430.5 administered by the commissioner, has met the continuing education requirements, if
 430.6 required, and has paid the fee set by the commissioner. The commissioner may reject or
 430.7 deny an application for a certificate if there is evidence of a violation or failure to comply
 430.8 with this chapter.

430.9 (b) The commissioner shall not issue a certificate to an applicant who refuses to consent
 430.10 to a criminal history background check as required by section 144.0572 within 90 days after
 430.11 submission of an application or fails to submit fingerprints to the Department of Human
 430.12 Services. Any fees paid by the applicant to the Department of Health shall be forfeited if
 430.13 the applicant refuses to consent to the background study.

430.14 Sec. 129. Minnesota Statutes 2016, section 153A.17, is amended to read:

430.15 **153A.17 EXPENSES; FEES.**

430.16 (a) The expenses for administering the certification requirements, including the complaint
 430.17 handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the
 430.18 Consumer Information Center under section 153A.18, must be paid from initial application
 430.19 and examination fees, renewal fees, penalties, and fines. The commissioner shall only use
 430.20 fees collected under this section for the purposes of administering this chapter. The legislature
 430.21 must not transfer money generated by these fees from the state government special revenue
 430.22 fund to the general fund. Surcharges collected by the commissioner of health under section
 430.23 16E.22 are not subject to this paragraph.

430.24 (b) The fees are as follows:

430.25 (1) the initial ~~and annual renewal~~ certification application fee is ~~\$600~~ \$772.50;

430.26 (2) ~~the initial examination fee for the written portion is \$500, and for each time it is~~
 430.27 ~~taken, thereafter~~ the annual renewal certification application fee is \$750;

430.28 (3) the initial examination fee for the practical portion is \$1,200, and \$600 for each time
 430.29 it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision
 430.30 2, the fee for the practical portion of the hearing instrument dispensing examination is ~~\$250~~
 430.31 \$600 each time it is taken;

430.32 (4) the trainee application fee is ~~\$200~~ \$230;

431.1 (5) the penalty fee for late submission of a renewal application is ~~\$200~~ \$260; and

431.2 (6) the fee for verification of certification to other jurisdictions or entities is \$25.

431.3 (c) The commissioner may prorate the certification fee for new applicants based on the
431.4 number of quarters remaining in the annual certification period.

431.5 (d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited
431.6 in the state government special revenue fund.

431.7 (e) ~~Beginning July 1, 2009, until June 30, 2016, a surcharge of \$100 shall be paid at the~~
431.8 ~~time of initial certification application or renewal to recover the commissioner's accumulated~~
431.9 ~~direct expenditures for administering the requirements of this chapter. Hearing instrument~~
431.10 ~~dispensers who were certified before January 1, 2018, shall pay a onetime surcharge of~~
431.11 ~~\$22.50 to renew their certification when it expires after October 31, 2020. The surcharge~~
431.12 ~~shall cover the commissioner's costs associated with criminal background checks.~~

431.13 Sec. 130. Minnesota Statutes 2016, section 157.16, subdivision 1, is amended to read:

431.14 Subdivision 1. **License required annually.** A license is required annually for every
431.15 person, firm, or corporation engaged in the business of conducting a food and beverage
431.16 service establishment, youth camp, hotel, motel, lodging establishment, public pool, or
431.17 resort. Any person wishing to operate a place of business licensed in this section shall first
431.18 make application, pay the required fee specified in this section, and receive approval for
431.19 operation, including plan review approval. Special event food stands are not required to
431.20 submit plans. Nonprofit organizations operating a special event food stand with multiple
431.21 locations at an annual one-day event shall be issued only one license. Application shall be
431.22 made on forms provided by the commissioner and shall require the applicant to state the
431.23 full name and address of the owner of the building, structure, or enclosure, the lessee and
431.24 manager of the food and beverage service establishment, hotel, motel, lodging establishment,
431.25 public pool, or resort; the name under which the business is to be conducted; and any other
431.26 information as may be required by the commissioner to complete the application for license.
431.27 All fees collected under this section shall be deposited in the state government special
431.28 revenue fund.

431.29 Sec. 131. Minnesota Statutes 2016, section 157.16, subdivision 3, is amended to read:

431.30 Subd. 3. **Establishment fees; definitions.** (a) The following fees are required for food
431.31 and beverage service establishments, youth camps, hotels, motels, lodging establishments,
431.32 public pools, and resorts licensed under this chapter. Food and beverage service

432.1 establishments must pay the highest applicable fee under paragraph (d), clause (1), (2), (3),
 432.2 or (4), ~~and establishments serving alcohol must pay the highest applicable fee under paragraph~~
 432.3 ~~(d), clause (6) or (7).~~ The license fee for new operators previously licensed under this chapter
 432.4 for the same calendar year is one-half of the appropriate annual license fee, plus any penalty
 432.5 that may be required. The license fee for operators opening on or after October 1 is one-half
 432.6 of the appropriate annual license fee, plus any penalty that may be required.

432.7 (b) All food and beverage service establishments, except special event food stands, and
 432.8 all hotels, motels, lodging establishments, public pools, and resorts shall pay an annual base
 432.9 fee of ~~\$150~~ \$165.

432.10 (c) A special event food stand shall pay a flat fee of ~~\$50~~ \$55 annually. "Special event
 432.11 food stand" means a fee category where food is prepared or served in conjunction with
 432.12 celebrations, county fairs, or special events from a special event food stand as defined in
 432.13 section 157.15.

432.14 (d) In addition to the base fee in paragraph (b), each food and beverage service
 432.15 establishment, other than a special event food stand and a school concession stand, and each
 432.16 hotel, motel, lodging establishment, public pool, and resort shall pay an additional annual
 432.17 fee for each fee category, additional food service, or required additional inspection specified
 432.18 in this paragraph:

432.19 (1) ~~Limited food menu selection, \$60. "Limited food menu selection" Category 1~~
 432.20 establishment, \$110. "Category 1 establishment" means a fee category that provides one or
 432.21 more of the following items or is one of the listed establishments or facilities:

432.22 (i) serves prepackaged food that receives heat treatment and is served in the package;

432.23 (ii) ~~frozen pizza that is heated and served;~~

432.24 ~~(iii)~~ serves a continental breakfast such as rolls, coffee, juice, milk, and cold cereal;

432.25 ~~(iv)~~ (iii) serves soft drinks, coffee, or nonalcoholic beverages; ~~or~~

432.26 ~~(v)~~ (iv) provides cleaning for eating, drinking, or cooking utensils, when the only food
 432.27 served is prepared off site;

432.28 (v) a food establishment where the method of food preparation meets the definition of
 432.29 a low-risk establishment in section 157.20; or

432.30 (vi) operates as a child care facility licensed under section 245A.03 and Minnesota Rules,
 432.31 chapter 9503.

- 433.1 ~~(2) Small establishment, including boarding establishments, \$120. "Small establishment"~~
433.2 ~~means a fee category that has no salad bar and meets one or more of the following:~~
- 433.3 ~~(i) possesses food service equipment that consists of no more than a deep fat fryer, a~~
433.4 ~~grill, two hot holding containers, and one or more microwave ovens;~~
- 433.5 ~~(ii) serves dipped ice cream or soft serve frozen desserts;~~
- 433.6 ~~(iii) serves breakfast in an owner-occupied bed and breakfast establishment;~~
- 433.7 ~~(iv) is a boarding establishment; or~~
- 433.8 ~~(v) meets the equipment criteria in clause (3), item (i) or (ii), and has a maximum patron~~
433.9 ~~seating capacity of not more than 50.~~
- 433.10 ~~(3) Medium establishment, \$310. "Medium establishment" (2) Category 2 establishment,~~
433.11 ~~\$245. "Category 2 establishment" means a fee category that meets one or more of the~~
433.12 ~~following an establishment that is not a Category 1 establishment and is either:~~
- 433.13 ~~(i) possesses food service equipment that includes a range, oven, steam table, salad bar,~~
433.14 ~~or salad preparation area; a food establishment where the method of food preparation meets~~
433.15 ~~the definition of a medium-risk establishment in section 157.20; or~~
- 433.16 ~~(ii) possesses food service equipment that includes more than one deep fat fryer, one~~
433.17 ~~grill, or two hot holding containers; or an elementary or secondary school as defined in~~
433.18 ~~section 120A.05.~~
- 433.19 ~~(iii) is an establishment where food is prepared at one location and served at one or more~~
433.20 ~~separate locations.~~
- 433.21 ~~Establishments meeting criteria in clause (2), item (v), are not included in this fee~~
433.22 ~~category.~~
- 433.23 ~~(4) Large establishment, \$540. "Large establishment" (3) Category 3 establishment,~~
433.24 ~~\$385. "Category 3 establishment" means an establishment that is not a Category 1 or Category~~
433.25 ~~2 establishment and is either:~~
- 433.26 ~~(i) a fee category that (A) meets the criteria in clause (3), items (i) or (ii), for a medium~~
433.27 ~~establishment, (B) seats more than 175 people, and (C) offers the full menu selection an~~
433.28 ~~average of five or more days a week during the weeks of operation a food establishment~~
433.29 ~~where the method of food preparation meets the definition of a high-risk establishment in~~
433.30 ~~section 157.20; or~~

434.1 (ii) ~~a fee category that (A) meets the criteria in clause (3), item (iii), for a medium~~
434.2 ~~establishment, and (B) prepares and serves 500 or more meals per day.~~ an establishment
434.3 where 500 or more meals are prepared per day and served at one or more separate locations.

434.4 ~~(5)~~ (4) Other food and beverage service, including food carts, mobile food units, seasonal
434.5 temporary food stands, and seasonal permanent food stands, ~~\$60~~ \$85.

434.6 ~~(6) Beer or wine table service, \$60. "Beer or wine table service" means a fee category~~
434.7 ~~where the only alcoholic beverage service is beer or wine, served to customers seated at~~
434.8 ~~tables.~~

434.9 ~~(7) Alcoholic beverage service, other than beer or wine table service, \$165.~~

434.10 ~~"Alcohol beverage service, other than beer or wine table service" means a fee category~~
434.11 ~~where alcoholic mixed drinks are served or where beer or wine are served from a bar.~~

434.12 ~~(8)~~ (5) Lodging per sleeping accommodation unit, ~~\$10~~ \$11, including hotels, motels,
434.13 lodging establishments, and resorts, up to a maximum of ~~\$1,000~~ \$1,100. "Lodging per
434.14 sleeping accommodation unit" means a fee category including the number of guest rooms,
434.15 cottages, or other rental units of a hotel, motel, lodging establishment, or resort; or the
434.16 number of beds in a dormitory.

434.17 ~~(9)~~ (6) First public pool, ~~\$325~~ \$355; each additional public pool, ~~\$175~~ \$200. "Public
434.18 pool" means a fee category that has the meaning given in section 144.1222, subdivision 4.

434.19 ~~(10)~~ (7) First spa, ~~\$175~~ \$200; each additional spa, ~~\$100~~ \$110. "Spa pool" means a fee
434.20 category that has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

434.21 ~~(11)~~ (8) Private sewer or water, \$60. "Individual private water" means a fee category
434.22 with a water supply other than a community public water supply as defined in Minnesota
434.23 Rules, chapter 4720. "Individual private sewer" means a fee category with an individual
434.24 sewage treatment system which uses subsurface treatment and disposal.

434.25 ~~(12)~~ (9) Additional food service, ~~\$150~~ \$175. "Additional food service" means a location
434.26 at a food service establishment, other than the primary food preparation and service area,
434.27 used to prepare or serve beverages or food to the public. Additional food service does not
434.28 apply to school concession stands.

434.29 ~~(13)~~ (10) Additional inspection fee, ~~\$360~~ \$250. "Additional inspection fee" means a fee
434.30 to conduct the second inspection each year for elementary and secondary education facility
434.31 school lunch programs when required by the Richard B. Russell National School Lunch
434.32 Act.

435.1 (11) HACCP verification, \$175. "HACCP verification" means an annual fee category
 435.2 for a business that performs one or more specialized process that requires an HACCP plan
 435.3 as required in chapter 31 and Minnesota Rules, chapter 4626.

435.4 (e) A fee for review of construction plans must accompany the initial license application
 435.5 for restaurants, hotels, motels, lodging establishments, resorts, seasonal food stands, and
 435.6 mobile food units. A fee for review of an HACCP plan for specialized processing must be
 435.7 submitted and approved prior to preparing and serving the specialized processed food for
 435.8 human consumption. The fee fees for this construction plan review is reviews and HACCP
 435.9 plan reviews are as follows:

435.10	Service Area	Type	Fee
435.11	Food	limited food menu	\$275
435.12		small category 1 establishment	\$400
435.13		medium category 2 establishment	\$450
435.14		large category 3 food establishment	\$500
435.15			\$150
435.16		additional food service	<u>\$250</u>
435.17		<u>HACCP Plan Review</u>	<u>\$500</u>
435.18	Transient food service	food cart	\$250
435.19		seasonal permanent food stand	\$250
435.20		seasonal temporary food stand	\$250
435.21		mobile food unit	\$350
435.22	Alcohol	beer or wine table service	\$150
435.23		alcohol service from bar	\$250
435.24	Lodging	less than 25 rooms	\$375
435.25		25 to less than 100 rooms	\$400
435.26		100 rooms or more	\$500
435.27		less than five cabins	\$350
435.28		five to less than ten cabins	\$400
435.29		ten cabins or more	\$450

435.30 (f) When existing food and beverage service establishments, hotels, motels, lodging
 435.31 establishments, resorts, seasonal food stands, and mobile food units are extensively
 435.32 remodeled, a fee must be submitted with the remodeling plans. The fee for this construction
 435.33 plan review is as follows:

435.34	Service Area	Type	Fee
435.35	Food	limited food menu	\$250
435.36		small category 1 establishment	\$300

436.1		medium <u>category 2</u> establishment	\$350
436.2		large food <u>category 3</u> establishment	\$400
436.3			\$150
436.4		additional food service	<u>\$250</u>
436.5	Transient food service	food cart	\$250
436.6		seasonal permanent food stand	\$250
436.7		seasonal temporary food stand	\$250
436.8		mobile food unit	\$250
436.9	Alcohol	beer or wine table service	\$150
436.10		alcohol service from bar	\$250
436.11	Lodging	less than 25 rooms	\$250
436.12		25 to less than 100 rooms	\$300
436.13		100 rooms or more	\$450
436.14		less than five cabins	\$250
436.15		five to less than ten cabins	\$350
436.16		ten cabins or more	\$400

436.17 (g) Special event food stands are not required to submit construction or remodeling plans
436.18 for review.

436.19 (h) Youth camps shall pay an annual single fee for food and lodging as follows:

436.20 (1) camps with up to 99 campers, \$325;

436.21 (2) camps with 100 to 199 campers, \$550; and

436.22 (3) camps with 200 or more campers, \$750.

436.23 (i) A youth camp which pays fees under paragraph (d) is not required to pay fees under
436.24 paragraph (h).

436.25 Sec. 132. Minnesota Statutes 2016, section 157.16, subdivision 3a, is amended to read:

436.26 Subd. 3a. **Statewide hospitality fee.** Every person, firm, or corporation that operates a
436.27 licensed boarding establishment, food and beverage service establishment, seasonal temporary
436.28 or permanent food stand, special event food stand, mobile food unit, food cart, resort, hotel,
436.29 motel, or lodging establishment in Minnesota must submit to the commissioner a ~~\$35~~ \$40
436.30 annual statewide hospitality fee for each licensed activity. The fee for establishments licensed
436.31 by the Department of Health is required at the same time the licensure fee is due. For
436.32 establishments licensed by local governments, the fee is due by July 1 of each year.

437.1 Sec. 133. Minnesota Statutes 2016, section 245C.10, is amended by adding a subdivision
437.2 to read:

437.3 **Subd. 2a. Occupations regulated by commissioner of health.** The commissioner shall
437.4 set fees to recover the cost of combined background studies and criminal background checks
437.5 initiated by applicants, licensees, and certified practitioners regulated under sections 148.511
437.6 to 148.5198 and chapter 153A. The fees collected under this subdivision shall be deposited
437.7 in the special revenue fund and are appropriated to the commissioner for the purpose of
437.8 conducting background studies and criminal background checks.

437.9 Sec. 134. Minnesota Statutes 2016, section 327.15, subdivision 3, is amended to read:

437.10 **Subd. 3. Fees, manufactured home parks and recreational camping areas.** (a) The
437.11 following fees are required for manufactured home parks and recreational camping areas
437.12 licensed under this chapter. Fees collected under this section shall be deposited in the state
437.13 government special revenue fund. Recreational camping areas and manufactured home
437.14 parks shall pay the highest applicable base fee under paragraph (b). The license fee for new
437.15 operators of a manufactured home park or recreational camping area previously licensed
437.16 under this chapter for the same calendar year is one-half of the appropriate annual license
437.17 fee, plus any penalty that may be required. The license fee for operators opening on or after
437.18 October 1 is one-half of the appropriate annual license fee, plus any penalty that may be
437.19 required.

437.20 (b) All manufactured home parks and recreational camping areas shall pay the following
437.21 annual base fee:

437.22 (1) a manufactured home park, ~~\$150~~ \$165; and

437.23 (2) a recreational camping area with:

437.24 (i) 24 or less sites, ~~\$50~~ \$55;

437.25 (ii) 25 to 99 sites, ~~\$212~~ \$230; and

437.26 (iii) 100 or more sites, ~~\$300~~ \$330.

437.27 In addition to the base fee, manufactured home parks and recreational camping areas shall
437.28 pay ~~\$4~~ \$5 for each licensed site. This paragraph does not apply to special event recreational
437.29 camping areas. Operators of a manufactured home park or a recreational camping area also
437.30 licensed under section 157.16 for the same location shall pay only one base fee, whichever
437.31 is the highest of the base fees found in this section or section 157.16.

438.1 (c) In addition to the fee in paragraph (b), each manufactured home park or recreational
438.2 camping area shall pay an additional annual fee for each fee category specified in this
438.3 paragraph:

438.4 (1) Manufactured home parks and recreational camping areas with public swimming
438.5 pools and spas shall pay the appropriate fees specified in section 157.16.

438.6 (2) Individual private sewer or water, \$60. "Individual private water" means a fee category
438.7 with a water supply other than a community public water supply as defined in Minnesota
438.8 Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface
438.9 sewage treatment system which uses subsurface treatment and disposal.

438.10 (d) The following fees must accompany a plan review application for initial construction
438.11 of a manufactured home park or recreational camping area:

438.12 (1) for initial construction of less than 25 sites, \$375;

438.13 (2) for initial construction of 25 to 99 sites, \$400; and

438.14 (3) for initial construction of 100 or more sites, \$500.

438.15 (e) The following fees must accompany a plan review application when an existing
438.16 manufactured home park or recreational camping area is expanded:

438.17 (1) for expansion of less than 25 sites, \$250;

438.18 (2) for expansion of 25 to 99 sites, \$300; and

438.19 (3) for expansion of 100 or more sites, \$450.

438.20 Sec. 135. Minnesota Statutes 2016, section 364.09, is amended to read:

438.21 **364.09 EXCEPTIONS.**

438.22 (a) This chapter does not apply to the licensing process for peace officers; to law
438.23 enforcement agencies as defined in section 626.84, subdivision 1, paragraph (f); to fire
438.24 protection agencies; to eligibility for a private detective or protective agent license; to the
438.25 licensing and background study process under chapters 245A and 245C; to the licensing
438.26 and background investigation process under chapter 240; to eligibility for school bus driver
438.27 endorsements; to eligibility for special transportation service endorsements; to eligibility
438.28 for a commercial driver training instructor license, which is governed by section 171.35
438.29 and rules adopted under that section; to emergency medical services personnel, or to the
438.30 licensing by political subdivisions of taxicab drivers, if the applicant for the license has

439.1 been discharged from sentence for a conviction within the ten years immediately preceding
439.2 application of a violation of any of the following:

439.3 (1) sections 609.185 to 609.2114, 609.221 to 609.223, 609.342 to 609.3451, or 617.23,
439.4 subdivision 2 or 3; or Minnesota Statutes 2012, section 609.21;

439.5 (2) any provision of chapter 152 that is punishable by a maximum sentence of 15 years
439.6 or more; or

439.7 (3) a violation of chapter 169 or 169A involving driving under the influence, leaving
439.8 the scene of an accident, or reckless or careless driving.

439.9 This chapter also shall not apply to eligibility for juvenile corrections employment, where
439.10 the offense involved child physical or sexual abuse or criminal sexual conduct.

439.11 (b) This chapter does not apply to a school district or to eligibility for a license issued
439.12 or renewed by the Board of Teaching or the commissioner of education.

439.13 (c) Nothing in this section precludes the Minnesota Police and Peace Officers Training
439.14 Board or the state fire marshal from recommending policies set forth in this chapter to the
439.15 attorney general for adoption in the attorney general's discretion to apply to law enforcement
439.16 or fire protection agencies.

439.17 (d) This chapter does not apply to a license to practice medicine that has been denied or
439.18 revoked by the Board of Medical Practice pursuant to section 147.091, subdivision 1a.

439.19 (e) This chapter does not apply to any person who has been denied a license to practice
439.20 chiropractic or whose license to practice chiropractic has been revoked by the board in
439.21 accordance with section 148.10, subdivision 7.

439.22 (f) This chapter does not apply to any license, registration, or permit that has been denied
439.23 or revoked by the Board of Nursing in accordance with section 148.261, subdivision 1a.

439.24 (g) This chapter does not apply to any license, registration, permit, or certificate that has
439.25 been denied or revoked by the commissioner of health according to section 148.5195,
439.26 subdivision 5; or 153A.15, subdivision 2.

439.27 ~~(g)~~ (h) This chapter does not supersede a requirement under law to conduct a criminal
439.28 history background investigation or consider criminal history records in hiring for particular
439.29 types of employment.

440.1 Sec. 136. Minnesota Statutes 2016, section 609.5315, subdivision 5c, is amended to read:

440.2 Subd. 5c. **Disposition of money; prostitution.** Money forfeited under section 609.5312,
440.3 subdivision 1, paragraph (b), must be distributed as follows:

440.4 (1) 40 percent must be forwarded to the appropriate agency for deposit as a supplement
440.5 to the agency's operating fund or similar fund for use in law enforcement;

440.6 (2) 20 percent must be forwarded to the prosecuting authority that handled the forfeiture
440.7 for deposit as a supplement to its operating fund or similar fund for prosecutorial purposes;
440.8 and

440.9 (3) the remaining 40 percent must be forwarded to the commissioner of ~~public safety~~
440.10 health to be deposited in the safe harbor for youth account in the special revenue fund and
440.11 is appropriated to the commissioner for distribution to crime victims services organizations
440.12 that provide services to sexually exploited youth, as defined in section 260C.007, subdivision
440.13 31.

440.14 Sec. 137. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

440.15 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
440.16 given them unless the specific content indicates otherwise:

440.17 (a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence
440.18 or event which:

440.19 (1) is not likely to occur and could not have been prevented by exercise of due care; and

440.20 (2) if occurring while a child is receiving services from a facility, happens when the
440.21 facility and the employee or person providing services in the facility are in compliance with
440.22 the laws and rules relevant to the occurrence or event.

440.23 (b) "Commissioner" means the commissioner of human services.

440.24 (c) "Facility" means:

440.25 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
440.26 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
440.27 144.58, 241.021, or 245A.01 to 245A.16, or chapter 144H or 245D;

440.28 (2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E;
440.29 or

440.30 (3) a nonlicensed personal care provider organization as defined in section 256B.0625,
440.31 subdivision 19a.

441.1 (d) "Family assessment" means a comprehensive assessment of child safety, risk of
441.2 subsequent child maltreatment, and family strengths and needs that is applied to a child
441.3 maltreatment report that does not allege sexual abuse or substantial child endangerment.
441.4 Family assessment does not include a determination as to whether child maltreatment
441.5 occurred but does determine the need for services to address the safety of family members
441.6 and the risk of subsequent maltreatment.

441.7 (e) "Investigation" means fact gathering related to the current safety of a child and the
441.8 risk of subsequent maltreatment that determines whether child maltreatment occurred and
441.9 whether child protective services are needed. An investigation must be used when reports
441.10 involve sexual abuse or substantial child endangerment, and for reports of maltreatment in
441.11 facilities required to be licensed under chapter 245A or 245D; under sections 144.50 to
441.12 144.58 and 241.021; in a school as defined in section 120A.05, subdivisions 9, 11, and 13,
441.13 and chapter 124E; or in a nonlicensed personal care provider association as defined in section
441.14 256B.0625, subdivision 19a.

441.15 (f) "Mental injury" means an injury to the psychological capacity or emotional stability
441.16 of a child as evidenced by an observable or substantial impairment in the child's ability to
441.17 function within a normal range of performance and behavior with due regard to the child's
441.18 culture.

441.19 (g) "Neglect" means the commission or omission of any of the acts specified under
441.20 clauses (1) to (9), other than by accidental means:

441.21 (1) failure by a person responsible for a child's care to supply a child with necessary
441.22 food, clothing, shelter, health, medical, or other care required for the child's physical or
441.23 mental health when reasonably able to do so;

441.24 (2) failure to protect a child from conditions or actions that seriously endanger the child's
441.25 physical or mental health when reasonably able to do so, including a growth delay, which
441.26 may be referred to as a failure to thrive, that has been diagnosed by a physician and is due
441.27 to parental neglect;

441.28 (3) failure to provide for necessary supervision or child care arrangements appropriate
441.29 for a child after considering factors as the child's age, mental ability, physical condition,
441.30 length of absence, or environment, when the child is unable to care for the child's own basic
441.31 needs or safety, or the basic needs or safety of another child in their care;

441.32 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
441.33 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's

442.1 child with sympathomimetic medications, consistent with section 125A.091, subdivision
442.2 5;

442.3 (5) nothing in this section shall be construed to mean that a child is neglected solely
442.4 because the child's parent, guardian, or other person responsible for the child's care in good
442.5 faith selects and depends upon spiritual means or prayer for treatment or care of disease or
442.6 remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker,
442.7 or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of
442.8 medical care may cause serious danger to the child's health. This section does not impose
442.9 upon persons, not otherwise legally responsible for providing a child with necessary food,
442.10 clothing, shelter, education, or medical care, a duty to provide that care;

442.11 (6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision
442.12 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in
442.13 the child at birth, results of a toxicology test performed on the mother at delivery or the
442.14 child at birth, medical effects or developmental delays during the child's first year of life
442.15 that medically indicate prenatal exposure to a controlled substance, or the presence of a
442.16 fetal alcohol spectrum disorder;

442.17 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

442.18 (8) chronic and severe use of alcohol or a controlled substance by a parent or person
442.19 responsible for the care of the child that adversely affects the child's basic needs and safety;
442.20 or

442.21 (9) emotional harm from a pattern of behavior which contributes to impaired emotional
442.22 functioning of the child which may be demonstrated by a substantial and observable effect
442.23 in the child's behavior, emotional response, or cognition that is not within the normal range
442.24 for the child's age and stage of development, with due regard to the child's culture.

442.25 (h) "Nonmaltreatment mistake" means:

442.26 (1) at the time of the incident, the individual was performing duties identified in the
442.27 center's child care program plan required under Minnesota Rules, part 9503.0045;

442.28 (2) the individual has not been determined responsible for a similar incident that resulted
442.29 in a finding of maltreatment for at least seven years;

442.30 (3) the individual has not been determined to have committed a similar nonmaltreatment
442.31 mistake under this paragraph for at least four years;

443.1 (4) any injury to a child resulting from the incident, if treated, is treated only with
443.2 remedies that are available over the counter, whether ordered by a medical professional or
443.3 not; and

443.4 (5) except for the period when the incident occurred, the facility and the individual
443.5 providing services were both in compliance with all licensing requirements relevant to the
443.6 incident.

443.7 This definition only applies to child care centers licensed under Minnesota Rules, chapter
443.8 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated
443.9 maltreatment by the individual, the commissioner of human services shall determine that a
443.10 nonmaltreatment mistake was made by the individual.

443.11 (i) "Operator" means an operator or agency as defined in section 245A.02.

443.12 (j) "Person responsible for the child's care" means (1) an individual functioning within
443.13 the family unit and having responsibilities for the care of the child such as a parent, guardian,
443.14 or other person having similar care responsibilities, or (2) an individual functioning outside
443.15 the family unit and having responsibilities for the care of the child such as a teacher, school
443.16 administrator, other school employees or agents, or other lawful custodian of a child having
443.17 either full-time or short-term care responsibilities including, but not limited to, day care,
443.18 babysitting whether paid or unpaid, counseling, teaching, and coaching.

443.19 (k) "Physical abuse" means any physical injury, mental injury, or threatened injury,
443.20 inflicted by a person responsible for the child's care on a child other than by accidental
443.21 means, or any physical or mental injury that cannot reasonably be explained by the child's
443.22 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
443.23 that have not been authorized under section 125A.0942 or 245.825.

443.24 Abuse does not include reasonable and moderate physical discipline of a child
443.25 administered by a parent or legal guardian which does not result in an injury. Abuse does
443.26 not include the use of reasonable force by a teacher, principal, or school employee as allowed
443.27 by section 121A.582. Actions which are not reasonable and moderate include, but are not
443.28 limited to, any of the following:

443.29 (1) throwing, kicking, burning, biting, or cutting a child;

443.30 (2) striking a child with a closed fist;

443.31 (3) shaking a child under age three;

443.32 (4) striking or other actions which result in any nonaccidental injury to a child under 18
443.33 months of age;

- 444.1 (5) unreasonable interference with a child's breathing;
- 444.2 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;
- 444.3 (7) striking a child under age one on the face or head;
- 444.4 (8) striking a child who is at least age one but under age four on the face or head, which
444.5 results in an injury;
- 444.6 (9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
444.7 substances which were not prescribed for the child by a practitioner, in order to control or
444.8 punish the child; or other substances that substantially affect the child's behavior, motor
444.9 coordination, or judgment or that results in sickness or internal injury, or subjects the child
444.10 to medical procedures that would be unnecessary if the child were not exposed to the
444.11 substances;
- 444.12 (10) unreasonable physical confinement or restraint not permitted under section 609.379,
444.13 including but not limited to tying, caging, or chaining; or
- 444.14 (11) in a school facility or school zone, an act by a person responsible for the child's
444.15 care that is a violation under section 121A.58.
- 444.16 (l) "Practice of social services," for the purposes of subdivision 3, includes but is not
444.17 limited to employee assistance counseling and the provision of guardian ad litem and
444.18 parenting time expeditor services.
- 444.19 (m) "Report" means any communication received by the local welfare agency, police
444.20 department, county sheriff, or agency responsible for child protection pursuant to this section
444.21 that describes neglect or physical or sexual abuse of a child and contains sufficient content
444.22 to identify the child and any person believed to be responsible for the neglect or abuse, if
444.23 known.
- 444.24 (n) "Sexual abuse" means the subjection of a child by a person responsible for the child's
444.25 care, by a person who has a significant relationship to the child, as defined in section 609.341,
444.26 or by a person in a position of authority, as defined in section 609.341, subdivision 10, to
444.27 any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first
444.28 degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual
444.29 conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or
444.30 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act
444.31 which involves a minor which constitutes a violation of prostitution offenses under sections
444.32 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports
444.33 of known or suspected child sex trafficking involving a child who is identified as a victim

445.1 of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321,
445.2 subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the
445.3 status of a parent or household member who has committed a violation which requires
445.4 registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or
445.5 required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

445.6 (o) "Substantial child endangerment" means a person responsible for a child's care, by
445.7 act or omission, commits or attempts to commit an act against a child under their care that
445.8 constitutes any of the following:

445.9 (1) egregious harm as defined in section 260C.007, subdivision 14;

445.10 (2) abandonment under section 260C.301, subdivision 2;

445.11 (3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's
445.12 physical or mental health, including a growth delay, which may be referred to as failure to
445.13 thrive, that has been diagnosed by a physician and is due to parental neglect;

445.14 (4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

445.15 (5) manslaughter in the first or second degree under section 609.20 or 609.205;

445.16 (6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

445.17 (7) solicitation, inducement, and promotion of prostitution under section 609.322;

445.18 (8) criminal sexual conduct under sections 609.342 to 609.3451;

445.19 (9) solicitation of children to engage in sexual conduct under section 609.352;

445.20 (10) malicious punishment or neglect or endangerment of a child under section 609.377
445.21 or 609.378;

445.22 (11) use of a minor in sexual performance under section 617.246; or

445.23 (12) parental behavior, status, or condition which mandates that the county attorney file
445.24 a termination of parental rights petition under section 260C.503, subdivision 2.

445.25 (p) "Threatened injury" means a statement, overt act, condition, or status that represents
445.26 a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes,
445.27 but is not limited to, exposing a child to a person responsible for the child's care, as defined
445.28 in paragraph (j), clause (1), who has:

445.29 (1) subjected a child to, or failed to protect a child from, an overt act or condition that
445.30 constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law
445.31 of another jurisdiction;

446.1 (2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph
446.2 (b), clause (4), or a similar law of another jurisdiction;

446.3 (3) committed an act that has resulted in an involuntary termination of parental rights
446.4 under section 260C.301, or a similar law of another jurisdiction; or

446.5 (4) committed an act that has resulted in the involuntary transfer of permanent legal and
446.6 physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201,
446.7 subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law
446.8 of another jurisdiction.

446.9 A child is the subject of a report of threatened injury when the responsible social services
446.10 agency receives birth match data under paragraph (q) from the Department of Human
446.11 Services.

446.12 (q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth
446.13 record or recognition of parentage identifying a child who is subject to threatened injury
446.14 under paragraph (p), the Department of Human Services shall send the data to the responsible
446.15 social services agency. The data is known as "birth match" data. Unless the responsible
446.16 social services agency has already begun an investigation or assessment of the report due
446.17 to the birth of the child or execution of the recognition of parentage and the parent's previous
446.18 history with child protection, the agency shall accept the birth match data as a report under
446.19 this section. The agency may use either a family assessment or investigation to determine
446.20 whether the child is safe. All of the provisions of this section apply. If the child is determined
446.21 to be safe, the agency shall consult with the county attorney to determine the appropriateness
446.22 of filing a petition alleging the child is in need of protection or services under section
446.23 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is
446.24 determined not to be safe, the agency and the county attorney shall take appropriate action
446.25 as required under section 260C.503, subdivision 2.

446.26 (r) Persons who conduct assessments or investigations under this section shall take into
446.27 account accepted child-rearing practices of the culture in which a child participates and
446.28 accepted teacher discipline practices, which are not injurious to the child's health, welfare,
446.29 and safety.

446.30 Sec. 138. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

446.31 Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person
446.32 who knows or has reason to believe a child is being neglected or physically or sexually
446.33 abused, as defined in subdivision 2, or has been neglected or physically or sexually abused

447.1 within the preceding three years, shall immediately report the information to the local welfare
447.2 agency, agency responsible for assessing or investigating the report, police department,
447.3 county sheriff, tribal social services agency, or tribal police department if the person is:

447.4 (1) a professional or professional's delegate who is engaged in the practice of the healing
447.5 arts, social services, hospital administration, psychological or psychiatric treatment, child
447.6 care, education, correctional supervision, probation and correctional services, or law
447.7 enforcement; or

447.8 (2) employed as a member of the clergy and received the information while engaged in
447.9 ministerial duties, provided that a member of the clergy is not required by this subdivision
447.10 to report information that is otherwise privileged under section 595.02, subdivision 1,
447.11 paragraph (c).

447.12 (b) Any person may voluntarily report to the local welfare agency, agency responsible
447.13 for assessing or investigating the report, police department, county sheriff, tribal social
447.14 services agency, or tribal police department if the person knows, has reason to believe, or
447.15 suspects a child is being or has been neglected or subjected to physical or sexual abuse.

447.16 (c) A person mandated to report physical or sexual child abuse or neglect occurring
447.17 within a licensed facility shall report the information to the agency responsible for licensing
447.18 the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 144H
447.19 or 245D; or a nonlicensed personal care provider organization as defined in section
447.20 256B.0625, subdivision ~~19~~ 19a. A health or corrections agency receiving a report may
447.21 request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and
447.22 10b. A board or other entity whose licensees perform work within a school facility, upon
447.23 receiving a complaint of alleged maltreatment, shall provide information about the
447.24 circumstances of the alleged maltreatment to the commissioner of education. Section 13.03,
447.25 subdivision 4, applies to data received by the commissioner of education from a licensing
447.26 entity.

447.27 (d) Notification requirements under subdivision 10 apply to all reports received under
447.28 this section.

447.29 (e) For purposes of this section, "immediately" means as soon as possible but in no event
447.30 longer than 24 hours.

447.31 Sec. 139. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

447.32 Subd. 3c. **Local welfare agency, Department of Human Services or Department of**
447.33 **Health responsible for assessing or investigating reports of maltreatment.** (a) The county

448.1 local welfare agency is the agency responsible for assessing or investigating allegations of
448.2 maltreatment in child foster care, family child care, legally unlicensed child care, juvenile
448.3 correctional facilities licensed under section 241.021 located in the local welfare agency's
448.4 county, and reports involving children served by an unlicensed personal care provider
448.5 organization under section 256B.0659. Copies of findings related to personal care provider
448.6 organizations under section 256B.0659 must be forwarded to the Department of Human
448.7 Services provider enrollment.

448.8 (b) The Department of Human Services is the agency responsible for assessing or
448.9 investigating allegations of maltreatment in facilities licensed under chapters 245A and
448.10 245D, except for child foster care and family child care.

448.11 (c) The Department of Health is the agency responsible for assessing or investigating
448.12 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
448.13 144A.43 to 144A.482 or chapter 144H.

448.14 Sec. 140. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

448.15 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received
448.16 that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the
448.17 care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
448.18 sanitarium, or other facility or institution required to be licensed according to sections 144.50
448.19 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 144H or 245D, or a school as defined
448.20 in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal
448.21 care provider organization as defined in section 256B.0625, subdivision 19a, the
448.22 commissioner of the agency responsible for assessing or investigating the report or local
448.23 welfare agency investigating the report shall provide the following information to the parent,
448.24 guardian, or legal custodian of a child alleged to have been neglected, physically abused,
448.25 sexually abused, or the victim of maltreatment of a child in the facility: the name of the
448.26 facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment
448.27 of a child in the facility has been received; the nature of the alleged neglect, physical abuse,
448.28 sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an
448.29 assessment or investigation; any protective or corrective measures being taken pending the
448.30 outcome of the investigation; and that a written memorandum will be provided when the
448.31 investigation is completed.

448.32 (b) The commissioner of the agency responsible for assessing or investigating the report
448.33 or local welfare agency may also provide the information in paragraph (a) to the parent,
448.34 guardian, or legal custodian of any other child in the facility if the investigative agency

449.1 knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or
449.2 maltreatment of a child in the facility has occurred. In determining whether to exercise this
449.3 authority, the commissioner of the agency responsible for assessing or investigating the
449.4 report or local welfare agency shall consider the seriousness of the alleged neglect, physical
449.5 abuse, sexual abuse, or maltreatment of a child in the facility; the number of children
449.6 allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a
449.7 child in the facility; the number of alleged perpetrators; and the length of the investigation.
449.8 The facility shall be notified whenever this discretion is exercised.

449.9 (c) When the commissioner of the agency responsible for assessing or investigating the
449.10 report or local welfare agency has completed its investigation, every parent, guardian, or
449.11 legal custodian previously notified of the investigation by the commissioner or local welfare
449.12 agency shall be provided with the following information in a written memorandum: the
449.13 name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual
449.14 abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the
449.15 investigation findings; a statement whether maltreatment was found; and the protective or
449.16 corrective measures that are being or will be taken. The memorandum shall be written in a
449.17 manner that protects the identity of the reporter and the child and shall not contain the name,
449.18 or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed
449.19 during the investigation. If maltreatment is determined to exist, the commissioner or local
449.20 welfare agency shall also provide the written memorandum to the parent, guardian, or legal
449.21 custodian of each child in the facility who had contact with the individual responsible for
449.22 the maltreatment. When the facility is the responsible party for maltreatment, the
449.23 commissioner or local welfare agency shall also provide the written memorandum to the
449.24 parent, guardian, or legal custodian of each child who received services in the population
449.25 of the facility where the maltreatment occurred. This notification must be provided to the
449.26 parent, guardian, or legal custodian of each child receiving services from the time the
449.27 maltreatment occurred until either the individual responsible for maltreatment is no longer
449.28 in contact with a child or children in the facility or the conclusion of the investigation. In
449.29 the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions
449.30 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification
449.31 to parents, guardians, or legal custodians of each child in the facility, but shall, within ten
449.32 days after the investigation is completed, provide written notification to the parent, guardian,
449.33 or legal custodian of any student alleged to have been maltreated. The commissioner of
449.34 education may notify the parent, guardian, or legal custodian of any student involved as a
449.35 witness to alleged maltreatment.

450.1 Sec. 141. **RECOMMENDATIONS FOR SAFETY AND QUALITY IMPROVEMENT**
450.2 **PRACTICES FOR LONG-TERM CARE SERVICES AND SUPPORTS.**

450.3 The commissioner of health shall consult with interested stakeholders to consider:

450.4 (1) systems improvements in processes used by the Office of Health Facility Complaints
450.5 to investigate reports of maltreatment of vulnerable adults received by the office and
450.6 processes used to report maltreatment to the office; and

450.7 (2) options for implementing prevention strategies, alternative reporting approaches,
450.8 and proven patient safety and quality improvement practices and infrastructure for long-term
450.9 care services and supports.

450.10 Sec. 142. **STUDY AND REPORT ON HOME CARE NURSING WORKFORCE**
450.11 **SHORTAGE.**

450.12 (a) The chair and ranking minority member of the senate Human Services Reform
450.13 Finance and Policy Committee and the chair and ranking minority member of the house of
450.14 representatives Health and Human Services Finance Committee shall convene a working
450.15 group to study and report on the shortage of registered nurses and licensed practical nurses
450.16 available to provide low-complexity regular home care services to clients in need of such
450.17 services, especially clients covered by medical assistance, and to provide recommendations
450.18 for ways to address the workforce shortage. The working group shall consist of 14 members
450.19 appointed as follows:

450.20 (1) the chair of the senate Human Services Reform Finance and Policy Committee or a
450.21 designee;

450.22 (2) the ranking minority member of the senate Human Services Reform Finance and
450.23 Policy Committee or a designee;

450.24 (3) the chair of the house of representatives Health and Human Services Finance
450.25 Committee or a designee;

450.26 (4) the ranking minority member of the house of representatives Health and Human
450.27 Services Finance Committee or a designee;

450.28 (5) the commissioner of human services or a designee;

450.29 (6) the commissioner of health or a designee;

450.30 (7) one representative appointed by the Professional Home Care Coalition;

450.31 (8) one representative appointed by the Minnesota Home Care Association;

- 451.1 (9) one representative appointed by the Minnesota Board of Nursing;
- 451.2 (10) one representative appointed by the Minnesota Nurses Association;
- 451.3 (11) one representative appointed by the Minnesota Licensed Practical Nurses
- 451.4 Association;
- 451.5 (12) one representative appointed by the Minnesota Society of Medical Assistants;
- 451.6 (13) one client who receives regular home care nursing services and is covered by medical
- 451.7 assistance appointed by the commissioner of human services after consulting with the
- 451.8 appointing authorities identified in clauses (7) to (12); and
- 451.9 (14) one assessor appointed by the commissioner of human services. The assessor must
- 451.10 be certified under Minnesota Statutes, section 256B.0911, and must be a registered nurse.
- 451.11 (b) The appointing authorities must appoint members by August 1, 2017.
- 451.12 (c) The convening authorities shall convene the first meeting of the working group no
- 451.13 later than August 15, 2017, and caucus staff shall provide support and meeting space for
- 451.14 the working group. The Department of Health and the Department of Human Services shall
- 451.15 provide technical assistance to the working group by providing existing data and analysis
- 451.16 documenting the current and projected workforce shortages in the area of regular home care
- 451.17 nursing. The home care and assisted living program advisory council established under
- 451.18 Minnesota Statutes, section 144A.4799, shall provide advice and recommendations to the
- 451.19 working group. Working group members shall serve without compensation and shall not
- 451.20 be reimbursed for expenses.
- 451.21 (d) The working group shall:
- 451.22 (1) quantify the number of low-complexity regular home care nursing hours that are
- 451.23 authorized but not provided to clients covered by medical assistance, due to the shortage
- 451.24 of registered nurses and licensed practical nurses available to provide these home care
- 451.25 services;
- 451.26 (2) quantify the current and projected workforce shortages of registered nurses and
- 451.27 licensed practical nurses available to provide low-complexity regular home care nursing
- 451.28 services to clients, especially clients covered by medical assistance;
- 451.29 (3) develop recommendations for actions to take in the next two years to address the
- 451.30 regular home care nursing workforce shortage, including identifying other health care
- 451.31 professionals who may be able to provide low-complexity regular home care nursing services

452.1 with additional training; what additional training may be necessary for these health care
452.2 professionals; and how to address scope of practice and licensing issues;

452.3 (4) compile reimbursement rates for regular home care nursing from other states and
452.4 determine Minnesota's national ranking with respect to reimbursement for regular home
452.5 care nursing;

452.6 (5) determine whether reimbursement rates for regular home care nursing fully reimburse
452.7 providers for the cost of providing the service and whether the discrepancy, if any, between
452.8 rates and costs contributes to lack of access to regular home care nursing; and

452.9 (6) by January 15, 2018, report on the findings and recommendations of the working
452.10 group to the chairs and ranking minority members of the legislative committees with
452.11 jurisdiction over health and human services policy and finance. The working group's report
452.12 shall include draft legislation.

452.13 (e) The working group shall elect a chair from among its members at its first meeting.

452.14 (f) The meetings of the working group shall be open to the public.

452.15 (g) This section expires January 16, 2018, or the day after submitting the report required
452.16 by this section, whichever is earlier.

452.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

452.18 Sec. 143. **OPIOID ABUSE PREVENTION PILOT PROJECTS.**

452.19 (a) The commissioner of health shall establish opioid abuse prevention pilot projects in
452.20 geographic areas throughout the state based on the most recently available data on opioid
452.21 overdose and abuse rates, to reduce opioid abuse through the use of controlled substance
452.22 care teams and community-wide coordination of abuse-prevention initiatives. The
452.23 commissioner shall award grants to health care providers, health plan companies, local units
452.24 of government, tribal governments, or other entities to establish pilot projects.

452.25 (b) Each pilot project must:

452.26 (1) be designed to reduce emergency room and other health care provider visits resulting
452.27 from opioid use or abuse, and reduce rates of opioid addiction in the community;

452.28 (2) establish multidisciplinary controlled substance care teams, that may consist of
452.29 physicians, pharmacists, social workers, nurse care coordinators, and mental health
452.30 professionals;

453.1 (3) deliver health care services and care coordination, through controlled substance care
453.2 teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

453.3 (4) address any unmet social service needs that create barriers to managing pain
453.4 effectively and obtaining optimal health outcomes;

453.5 (5) provide prescriber and dispenser education and assistance to reduce the inappropriate
453.6 prescribing and dispensing of opioids;

453.7 (6) promote the adoption of best practices related to opioid disposal and reducing
453.8 opportunities for illegal access to opioids; and

453.9 (7) engage partners outside of the health care system, including schools, law enforcement,
453.10 and social services, to address root causes of opioid abuse and addiction at the community
453.11 level.

453.12 (c) The commissioner shall contract with an accountable community for health that
453.13 operates an opioid abuse prevention project, and can document success in reducing opioid
453.14 use through the use of controlled substance care teams, to assist the commissioner in
453.15 administering this section, and to provide technical assistance to the commissioner and to
453.16 entities selected to operate a pilot project.

453.17 (d) The contract under paragraph (c) shall require the accountable community for health
453.18 to evaluate the extent to which the pilot projects were successful in reducing the inappropriate
453.19 use of opioids. The evaluation must analyze changes in the number of opioid prescriptions,
453.20 the number of emergency room visits related to opioid use, and other relevant measures.
453.21 The accountable community for health shall report evaluation results to the chairs and
453.22 ranking minority members of the legislative committees with jurisdiction over health and
453.23 human services policy and finance and public safety by December 15, 2019.

453.24 (e) The commissioner may award one grant that, in addition to the other requirements
453.25 of this section, allows a root cause approach to reduce opioid abuse in an American Indian
453.26 community.

453.27 **Sec. 144. SAFE HARBOR FOR ALL; STATEWIDE SEX TRAFFICKING VICTIMS**
453.28 **STRATEGIC PLAN.**

453.29 (a) By October 1, 2018, the commissioner of health, in consultation with the
453.30 commissioners of public safety and human services, shall adopt a comprehensive strategic
453.31 plan to address the needs of sex trafficking victims statewide.

454.1 (b) The commissioner of health shall issue a request for proposals to select an organization
454.2 to develop the comprehensive strategic plan. The selected organization shall seek
454.3 recommendations from professionals, community members, and stakeholders from across
454.4 the state, with an emphasis on the communities most impacted by sex trafficking. At a
454.5 minimum, the selected organization must seek input from the following groups: sex
454.6 trafficking survivors and their family members, statewide crime victim services coalitions,
454.7 victim services providers, nonprofit organizations, task forces, prosecutors, public defenders,
454.8 tribal governments, public safety and corrections professionals, public health professionals,
454.9 human services professionals, and impacted community members. The strategic plan shall
454.10 include recommendations regarding the expansion of Minnesota's Safe Harbor Law to adult
454.11 victims of sex trafficking.

454.12 (c) By January 15, 2019, the commissioner of health shall report to the chairs and ranking
454.13 minority members of the legislative committees with jurisdiction over health and human
454.14 services and criminal justice finance and policy on developing the statewide strategic plan,
454.15 including recommendations for additional legislation and funding.

454.16 (d) As used in this section, "sex trafficking victim" has the meaning given in Minnesota
454.17 Statutes, section 609.321, subdivision 7b.

454.18 **Sec. 145. DIRECTION TO THE COMMISSIONER OF HEALTH.**

454.19 The commissioner of health shall work with interested stakeholders to evaluate whether
454.20 existing laws, including laws governing housing with services establishments, board and
454.21 lodging establishments with special services, assisted living designations, and home care
454.22 providers, as well as building code requirements and landlord tenancy laws, sufficiently
454.23 protect the health and safety of persons diagnosed with Alzheimer's disease or a related
454.24 dementia.

454.25 **Sec. 146. PALLIATIVE CARE ADVISORY COUNCIL.**

454.26 The appointing authorities shall appoint the first members of the Palliative Care Advisory
454.27 Council under Minnesota Statutes, section 144.059, by October 1, 2017. The commissioner
454.28 of health shall convene the first meeting by November 15, 2017, and the commissioner or
454.29 the commissioner's designee shall act as chair until the council elects a chair at its first
454.30 meeting.

455.1 Sec. 147. **REPEALER.**

455.2 Minnesota Statutes 2016, sections 103I.005, subdivisions 8, 14, and 15; 103I.451; and
455.3 144.0571, are repealed.

455.4 **ARTICLE 11**

455.5 **HEALTH LICENSING BOARDS**

455.6 Section 1. Minnesota Statutes 2016, section 147.01, subdivision 7, is amended to read:

455.7 Subd. 7. **Physician application fee and license fees.** (a) The board may charge a the
455.8 following nonrefundable application and license fees processed pursuant to sections 147.02,
455.9 147.03, 147.037, 147.0375, and 147.38:

455.10 (1) physician application fee of \$200;

455.11 (2) physician annual registration renewal fee, \$192;

455.12 (3) physician endorsement to other states, \$40;

455.13 (4) physician emeritus license, \$50;

455.14 (5) physician temporary licenses, \$60;

455.15 (6) physician late fee, \$60;

455.16 (7) duplicate license fee, \$20;

455.17 (8) certification letter fee, \$25;

455.18 (9) education or training program approval fee, \$100;

455.19 (10) report creation and generation fee, \$60;

455.20 (11) examination administration fee (half day), \$50;

455.21 (12) examination administration fee (full day), \$80; and

455.22 (13) fees developed by the Interstate Commission for determining physician qualification
455.23 to register and participate in the interstate medical licensure compact, as established in rules
455.24 authorized in and pursuant to section 147.38, not to exceed \$1,000.

455.25 (b) The board may prorate the initial annual license fee. All licensees are required to
455.26 pay the full fee upon license renewal. The revenue generated from the fee must be deposited
455.27 in an account in the state government special revenue fund.

456.1 Sec. 2. Minnesota Statutes 2016, section 147.02, subdivision 1, is amended to read:

456.2 Subdivision 1. **United States or Canadian medical school graduates.** The board shall
456.3 issue a license to practice medicine to a person not currently licensed in another state or
456.4 Canada and who meets the requirements in paragraphs (a) to (i).

456.5 (a) An applicant for a license shall file a written application on forms provided by the
456.6 board, showing to the board's satisfaction that the applicant is of good moral character and
456.7 satisfies the requirements of this section.

456.8 (b) The applicant shall present evidence satisfactory to the board of being a graduate of
456.9 a medical or osteopathic medical school located in the United States, its territories or Canada,
456.10 and approved by the board based upon its faculty, curriculum, facilities, accreditation by a
456.11 recognized national accrediting organization approved by the board, and other relevant data,
456.12 or is currently enrolled in the final year of study at the school.

456.13 (c) The applicant must have passed an examination as described in clause (1) or (2).

456.14 (1) The applicant must have passed a comprehensive examination for initial licensure
456.15 prepared and graded by the National Board of Medical Examiners, the Federation of State
456.16 Medical Boards, the Medical Council of Canada, the National Board of Osteopathic
456.17 Examiners, or the appropriate state board that the board determines acceptable. The board
456.18 shall by rule determine what constitutes a passing score in the examination.

456.19 (2) The applicant taking the United States Medical Licensing Examination (USMLE)
456.20 or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must
456.21 have passed steps or levels one, two, and three. Step or level three must be passed within
456.22 five years of passing step or level two, or before the end of residency training. The applicant
456.23 must pass each of steps or levels one, two, and three with passing scores as recommended
456.24 by the USMLE program or National Board of Osteopathic Medical Examiners within three
456.25 attempts. The applicant taking combinations of Federation of State Medical Boards, National
456.26 Board of Medical Examiners, and USMLE may be accepted only if the combination is
456.27 approved by the board as comparable to existing comparable examination sequences and
456.28 all examinations are completed prior to the year 2000.

456.29 (d) The applicant shall present evidence satisfactory to the board of the completion of
456.30 one year of graduate, clinical medical training in a program accredited by a national
456.31 accrediting organization approved by the board or other graduate training approved in
456.32 advance by the board as meeting standards similar to those of a national accrediting
456.33 organization.

457.1 (e) The applicant may make arrangements with the executive director to appear in person
457.2 before the board or its designated representative to show that the applicant satisfies the
457.3 requirements of this section. The board may establish as internal operating procedures the
457.4 procedures or requirements for the applicant's personal presentation.

457.5 (f) The applicant shall pay a nonrefundable fee established by the board ~~by rule~~. ~~The~~
457.6 ~~fee may not be refunded~~. Upon application or notice of license renewal, the board must
457.7 provide notice to the applicant and to the person whose license is scheduled to be issued or
457.8 renewed of any additional fees, surcharges, or other costs which the person is obligated to
457.9 pay as a condition of licensure. The notice must:

457.10 (1) state the dollar amount of the additional costs; and

457.11 (2) clearly identify to the applicant the payment schedule of additional costs.

457.12 (g) The applicant must not be under license suspension or revocation by the licensing
457.13 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
457.14 occurred.

457.15 (h) The applicant must not have engaged in conduct warranting disciplinary action
457.16 against a licensee, or have been subject to disciplinary action other than as specified in
457.17 paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph,
457.18 the board may issue a license only on the applicant's showing that the public will be protected
457.19 through issuance of a license with conditions and limitations the board considers appropriate.

457.20 (i) If the examination in paragraph (c) was passed more than ten years ago, the applicant
457.21 must either:

457.22 (1) pass the special purpose examination of the Federation of State Medical Boards with
457.23 a score of 75 or better within three attempts; or

457.24 (2) have a current certification by a specialty board of the American Board of Medical
457.25 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
457.26 Surgeons of Canada, or of the College of Family Physicians of Canada.

457.27 Sec. 3. Minnesota Statutes 2016, section 147.03, subdivision 1, is amended to read:

457.28 Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice
457.29 medicine to any person who satisfies the requirements in paragraphs (b) to ~~(f)~~(e).

457.30 (b) The applicant shall satisfy all the requirements established in section 147.02,
457.31 subdivision 1, paragraphs (a), (b), (d), (e), and (f).

457.32 (c) The applicant shall:

458.1 (1) have passed an examination prepared and graded by the Federation of State Medical
458.2 Boards, the National Board of Medical Examiners, or the United States Medical Licensing
458.3 Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph
458.4 (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council
458.5 of Canada; and

458.6 (2) have a current license from the equivalent licensing agency in another state or Canada
458.7 and, if the examination in clause (1) was passed more than ten years ago, either:

458.8 (i) pass the Special Purpose Examination of the Federation of State Medical Boards with
458.9 a score of 75 or better within three attempts; or

458.10 (ii) have a current certification by a specialty board of the American Board of Medical
458.11 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
458.12 Surgeons of Canada, or of the College of Family Physicians of Canada; or

458.13 (3) if the applicant fails to meet the requirement established in section 147.02, subdivision
458.14 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and
458.15 three of the USMLE within the required three attempts, the applicant may be granted a
458.16 license provided the applicant:

458.17 (i) has passed each of steps one, two, and three with passing scores as recommended by
458.18 the USMLE program within no more than four attempts for any of the three steps;

458.19 (ii) is currently licensed in another state; and

458.20 (iii) has current certification by a specialty board of the American Board of Medical
458.21 Specialties, the American Osteopathic Association Bureau of Professional Education, the
458.22 Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians
458.23 of Canada.

458.24 ~~(d) The applicant shall pay a fee established by the board by rule. The fee may not be~~
458.25 ~~refunded.~~

458.26 ~~(e)~~ (d) The applicant must not be under license suspension or revocation by the licensing
458.27 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
458.28 occurred.

458.29 ~~(f)~~ (e) The applicant must not have engaged in conduct warranting disciplinary action
458.30 against a licensee, or have been subject to disciplinary action other than as specified in
458.31 paragraph ~~(e)~~ (d). If an applicant does not satisfy the requirements stated in this paragraph,
458.32 the board may issue a license only on the applicant's showing that the public will be protected
458.33 through issuance of a license with conditions or limitations the board considers appropriate.

459.1 ~~(g)~~ (f) Upon the request of an applicant, the board may conduct the final interview of
459.2 the applicant by teleconference.

459.3 **Sec. 4. [147A.28] PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.**

459.4 (a) The board may charge the following nonrefundable fees:

459.5 (1) physician assistant application fee, \$120;

459.6 (2) physician assistant annual registration renewal fee (prescribing authority), \$135;

459.7 (3) physician assistant annual registration renewal fee (no prescribing authority), \$115;

459.8 (4) physician assistant temporary registration, \$115;

459.9 (5) physician assistant temporary permit, \$60;

459.10 (6) physician assistant locum tenens permit, \$25;

459.11 (7) physician assistant late fee, \$50;

459.12 (8) duplicate license fee, \$20;

459.13 (9) certification letter fee, \$25;

459.14 (10) education or training program approval fee, \$100; and

459.15 (11) report creation and generation fee, \$60.

459.16 (b) The board may prorate the initial annual license fee. All licensees are required to
459.17 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
459.18 in an account in the state government special revenue fund.

459.19 Sec. 5. Minnesota Statutes 2016, section 147B.08, is amended by adding a subdivision to
459.20 read:

459.21 **Subd. 4. Acupuncturist application and license fees.** (a) The board may charge the
459.22 following nonrefundable fees:

459.23 (1) acupuncturist application fee, \$150;

459.24 (2) acupuncturist annual registration renewal fee, \$150;

459.25 (3) acupuncturist temporary registration fee, \$60;

459.26 (4) acupuncturist inactive status fee, \$50;

459.27 (5) acupuncturist late fee, \$50;

459.28 (6) duplicate license fee, \$20;

460.1 (7) certification letter fee, \$25;

460.2 (8) education or training program approval fee, \$100; and

460.3 (9) report creation and generation fee, \$60.

460.4 (b) The board may prorate the initial annual license fee. All licensees are required to
 460.5 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
 460.6 in an account in the state government special revenue fund.

460.7 Sec. 6. Minnesota Statutes 2016, section 147C.40, is amended by adding a subdivision to
 460.8 read:

460.9 Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge
 460.10 the following nonrefundable fees:

460.11 (1) respiratory therapist application fee, \$100;

460.12 (2) respiratory therapist annual registration renewal fee, \$90;

460.13 (3) respiratory therapist inactive status fee, \$50;

460.14 (4) respiratory therapist temporary registration fee, \$90;

460.15 (5) respiratory therapist temporary permit, \$60;

460.16 (6) respiratory therapist late fee, \$50;

460.17 (7) duplicate license fee, \$20;

460.18 (8) certification letter fee, \$25;

460.19 (9) education or training program approval fee, \$100; and

460.20 (10) report creation and generation fee, \$60.

460.21 (b) The board may prorate the initial annual license fee. All licensees are required to
 460.22 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
 460.23 in an account in the state government special revenue fund.

460.24 Sec. 7. Minnesota Statutes 2016, section 148.6402, subdivision 4, is amended to read:

460.25 Subd. 4. ~~Commissioner Board.~~ "Commissioner Board" means the ~~commissioner of~~
 460.26 ~~health or a designee~~ Board of Occupational Therapy Practice established in section 148.6449.

460.27 **EFFECTIVE DATE.** This section is effective January 1, 2018.

461.1 Sec. 8. Minnesota Statutes 2016, section 148.6405, is amended to read:

461.2 **148.6405 LICENSURE APPLICATION REQUIREMENTS: PROCEDURES AND**
461.3 **QUALIFICATIONS.**

461.4 (a) An applicant for licensure must comply with the application requirements in section
461.5 148.6420. To qualify for licensure, an applicant must satisfy one of the requirements in
461.6 paragraphs (b) to (f) and not be subject to denial of licensure under section 148.6448.

461.7 (b) A person who applies for licensure as an occupational therapist and who has not
461.8 been credentialed by the National Board for Certification in Occupational Therapy or another
461.9 jurisdiction must meet the requirements in section 148.6408.

461.10 (c) A person who applies for licensure as an occupational therapy assistant and who has
461.11 not been credentialed by the National Board for Certification in Occupational Therapy or
461.12 another jurisdiction must meet the requirements in section 148.6410.

461.13 (d) A person who is certified by the National Board for Certification in Occupational
461.14 Therapy may apply for licensure by equivalency and must meet the requirements in section
461.15 148.6412.

461.16 (e) A person who is credentialed in another jurisdiction may apply for licensure by
461.17 reciprocity and must meet the requirements in section 148.6415.

461.18 (f) A person who applies for temporary licensure must meet the requirements in section
461.19 148.6418.

461.20 (g) A person who applies for licensure under paragraph (b), (c), or (f) more than two
461.21 and less than four years after meeting the requirements in section 148.6408 or 148.6410
461.22 must submit the following:

461.23 (1) a completed and signed application for licensure on forms provided by the
461.24 ~~commissioner~~ board;

461.25 (2) the license application fee required under section 148.6445;

461.26 (3) if applying for occupational therapist licensure, proof of having met a minimum of
461.27 24 contact hours of continuing education in the two years preceding licensure application,
461.28 or if applying for occupational therapy assistant licensure, proof of having met a minimum
461.29 of 18 contact hours of continuing education in the two years preceding licensure application;

461.30 (4) verified documentation of successful completion of 160 hours of supervised practice
461.31 approved by the ~~commissioner~~ board under a limited license specified in section 148.6425,
461.32 subdivision 3, paragraph (c); and

462.1 (5) additional information as requested by the ~~commissioner~~ board to clarify information
462.2 in the application, including information to determine whether the individual has engaged
462.3 in conduct warranting disciplinary action under section 148.6448. The information must be
462.4 submitted within 30 days after the ~~commissioner's~~ board's request.

462.5 (h) A person who applied for licensure under paragraph (b), (c), or (f) four years or more
462.6 after meeting the requirements in section 148.6408 or 148.6410 must meet all the
462.7 requirements in paragraph (g) except clauses (3) and (4), submit documentation of having
462.8 retaken and passed the credentialing examination for occupational therapist or occupational
462.9 therapy assistant, or of having completed an occupational therapy refresher program that
462.10 contains both a theoretical and clinical component approved by the ~~commissioner~~ board,
462.11 and verified documentation of successful completion of 480 hours of supervised practice
462.12 approved by the ~~commissioner~~ board under a limited license specified in section 148.6425,
462.13 subdivision 3, paragraph (c). The 480 hours of supervised practice must be completed in
462.14 six months and may be completed at the applicant's place of work. Only refresher courses
462.15 completed within one year prior to the date of application qualify for approval.

462.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

462.17 Sec. 9. Minnesota Statutes 2016, section 148.6408, subdivision 2, is amended to read:

462.18 Subd. 2. **Qualifying examination score required.** (a) An applicant must achieve a
462.19 qualifying score on the credentialing examination for occupational therapist.

462.20 (b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing
462.21 examination for occupational therapist. In determining the qualifying score, the ~~commissioner~~
462.22 board shall consider the cut score recommended by the National Board for Certification in
462.23 Occupational Therapy, or other national credentialing organization approved by the
462.24 ~~commissioner~~ board, using the modified Angoff method for determining cut score or another
462.25 method for determining cut score that is recognized as appropriate and acceptable by industry
462.26 standards.

462.27 (c) The applicant is responsible for:

462.28 (1) making arrangements to take the credentialing examination for occupational therapist;

462.29 (2) bearing all expenses associated with taking the examination; and

462.30 (3) having the examination scores sent directly to the ~~commissioner~~ board from the
462.31 testing service that administers the examination.

462.32 **EFFECTIVE DATE.** This section is effective January 1, 2018.

463.1 Sec. 10. Minnesota Statutes 2016, section 148.6410, subdivision 2, is amended to read:

463.2 Subd. 2. **Qualifying examination score required.** (a) An applicant for licensure must
463.3 achieve a qualifying score on the credentialing examination for occupational therapy
463.4 assistants.

463.5 (b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing
463.6 examination for occupational therapy assistants. In determining the qualifying score, the
463.7 ~~commissioner~~ board shall consider the cut score recommended by the National Board for
463.8 Certification in Occupational Therapy, or other national credentialing organization approved
463.9 by the ~~commissioner~~ board, using the modified Angoff method for determining cut score
463.10 or another method for determining cut score that is recognized as appropriate and acceptable
463.11 by industry standards.

463.12 (c) The applicant is responsible for:

463.13 (1) making all arrangements to take the credentialing examination for occupational
463.14 therapy assistants;

463.15 (2) bearing all expense associated with taking the examination; and

463.16 (3) having the examination scores sent directly to the ~~commissioner~~ board from the
463.17 testing service that administers the examination.

463.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

463.19 Sec. 11. Minnesota Statutes 2016, section 148.6412, subdivision 2, is amended to read:

463.20 Subd. 2. **Persons certified by National Board for Certification in Occupational**

463.21 **Therapy after June 17, 1996.** The ~~commissioner~~ board may license any person certified
463.22 by the National Board for Certification in Occupational Therapy as an occupational therapist
463.23 after June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification
463.24 are equivalent to or exceed the requirements for licensure as an occupational therapist under
463.25 section 148.6408. The ~~commissioner~~ board may license any person certified by the National
463.26 Board for Certification in Occupational Therapy as an occupational therapy assistant after
463.27 June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification are
463.28 equivalent to or exceed the requirements for licensure as an occupational therapy assistant
463.29 under section 148.6410. Nothing in this section limits the ~~commissioner's~~ board's authority
463.30 to deny licensure based upon the grounds for discipline in sections 148.6401 to ~~148.6450~~
463.31 148.6449.

463.32 **EFFECTIVE DATE.** This section is effective January 1, 2018.

464.1 Sec. 12. Minnesota Statutes 2016, section 148.6415, is amended to read:

464.2 **148.6415 LICENSURE BY RECIPROCITY.**

464.3 A person who holds a current credential as an occupational therapist in the District of
464.4 Columbia or a state or territory of the United States whose standards for credentialing are
464.5 determined by the ~~commissioner~~ board to be equivalent to or exceed the requirements for
464.6 licensure under section 148.6408 may be eligible for licensure by reciprocity as an
464.7 occupational therapist. A person who holds a current credential as an occupational therapy
464.8 assistant in the District of Columbia or a state or territory of the United States whose
464.9 standards for credentialing are determined by the ~~commissioner~~ board to be equivalent to
464.10 or exceed the requirements for licensure under section 148.6410 may be eligible for licensure
464.11 by reciprocity as an occupational therapy assistant. Nothing in this section limits the
464.12 ~~commissioner's~~ board's authority to deny licensure based upon the grounds for discipline
464.13 in sections 148.6401 to ~~148.6450~~ 148.6449. An applicant must provide:

464.14 (1) the application materials as required by section 148.6420, subdivisions 1, 3, and 4;

464.15 (2) the fees required by section 148.6445;

464.16 (3) a copy of a current and unrestricted credential for the practice of occupational therapy
464.17 as either an occupational therapist or occupational therapy assistant;

464.18 (4) a letter from the jurisdiction that issued the credential describing the applicant's
464.19 qualifications that entitled the applicant to receive the credential; and

464.20 (5) other information necessary to determine whether the credentialing standards of the
464.21 jurisdiction that issued the credential are equivalent to or exceed the requirements for
464.22 licensure under sections 148.6401 to ~~148.6450~~ 148.6449.

464.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

464.24 Sec. 13. Minnesota Statutes 2016, section 148.6418, subdivision 1, is amended to read:

464.25 Subdivision 1. **Application.** The ~~commissioner~~ board shall issue temporary licensure
464.26 as an occupational therapist or occupational therapy assistant to applicants who are not the
464.27 subject of a disciplinary action or past disciplinary action, nor disqualified on the basis of
464.28 items listed in section 148.6448, subdivision 1.

464.29 **EFFECTIVE DATE.** This section is effective January 1, 2018.

465.1 Sec. 14. Minnesota Statutes 2016, section 148.6418, subdivision 2, is amended to read:

465.2 Subd. 2. **Procedures.** To be eligible for temporary licensure, an applicant must submit
465.3 a completed application for temporary licensure on forms provided by the ~~commissioner~~
465.4 board, the fees required by section 148.6445, and one of the following:

465.5 (1) evidence of successful completion of the requirements in section 148.6408,
465.6 subdivision 1, or 148.6410, subdivision 1;

465.7 (2) a copy of a current and unrestricted credential for the practice of occupational therapy
465.8 as either an occupational therapist or occupational therapy assistant in another jurisdiction;
465.9 or

465.10 (3) a copy of a current and unrestricted certificate from the National Board for
465.11 Certification in Occupational Therapy stating that the applicant is certified as an occupational
465.12 therapist or occupational therapy assistant.

465.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

465.14 Sec. 15. Minnesota Statutes 2016, section 148.6418, subdivision 4, is amended to read:

465.15 Subd. 4. **Supervision required.** An applicant who has graduated from an accredited
465.16 occupational therapy program, as required by section 148.6408, subdivision 1, or 148.6410,
465.17 subdivision 1, and who has not passed the examination required by section 148.6408,
465.18 subdivision 2, or 148.6410, subdivision 2, must practice under the supervision of a licensed
465.19 occupational therapist. The supervising therapist must, at a minimum, supervise the person
465.20 working under temporary licensure in the performance of the initial evaluation, determination
465.21 of the appropriate treatment plan, and periodic review and modification of the treatment
465.22 plan. The supervising therapist must observe the person working under temporary licensure
465.23 in order to assure service competency in carrying out evaluation, treatment planning, and
465.24 treatment implementation. The frequency of face-to-face collaboration between the person
465.25 working under temporary licensure and the supervising therapist must be based on the
465.26 condition of each patient or client, the complexity of treatment and evaluation procedures,
465.27 and the proficiencies of the person practicing under temporary licensure. The occupational
465.28 therapist or occupational therapy assistant working under temporary licensure must provide
465.29 verification of supervision on the application form provided by the ~~commissioner~~ board.

465.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

466.1 Sec. 16. Minnesota Statutes 2016, section 148.6418, subdivision 5, is amended to read:

466.2 Subd. 5. **Expiration of temporary licensure.** A temporary license issued to a person
466.3 pursuant to subdivision 2, clause (1), expires six months from the date of issuance for
466.4 occupational therapists and occupational therapy assistants or on the date the ~~commissioner~~
466.5 board grants or denies licensure, whichever occurs first. A temporary license issued to a
466.6 person pursuant to subdivision 2, clause (2) or (3), expires 90 days after it is issued. Upon
466.7 application for renewal, a temporary license shall be renewed once to persons who have
466.8 not met the examination requirement under section 148.6408, subdivision 2, or 148.6410,
466.9 subdivision 2, within the initial temporary licensure period and who are not the subject of
466.10 a disciplinary action nor disqualified on the basis of items in section 148.6448, subdivision
466.11 1. Upon application for renewal, a temporary license shall be renewed once to persons who
466.12 are able to demonstrate good cause for failure to meet the requirements for licensure under
466.13 section 148.6412 or 148.6415 within the initial temporary licensure period and who are not
466.14 the subject of a disciplinary action nor disqualified on the basis of items in section 148.6448,
466.15 subdivision 1.

466.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

466.17 Sec. 17. Minnesota Statutes 2016, section 148.6420, subdivision 1, is amended to read:

466.18 Subdivision 1. **Applications for licensure.** An applicant for licensure must:

466.19 (1) submit a completed application for licensure on forms provided by the ~~commissioner~~
466.20 board and must supply the information requested on the application, including:

466.21 (i) the applicant's name, business address and business telephone number, business
466.22 setting, and daytime telephone number;

466.23 (ii) the name and location of the occupational therapy program the applicant completed;

466.24 (iii) a description of the applicant's education and training, including a list of degrees
466.25 received from educational institutions;

466.26 (iv) the applicant's work history for the six years preceding the application, including
466.27 the number of hours worked;

466.28 (v) a list of all credentials currently and previously held in Minnesota and other
466.29 jurisdictions;

466.30 (vi) a description of any jurisdiction's refusal to credential the applicant;

466.31 (vii) a description of all professional disciplinary actions initiated against the applicant
466.32 in any jurisdiction;

467.1 (viii) information on any physical or mental condition or chemical dependency that
467.2 impairs the person's ability to engage in the practice of occupational therapy with reasonable
467.3 judgment or safety;

467.4 (ix) a description of any misdemeanor or felony conviction that relates to honesty or to
467.5 the practice of occupational therapy;

467.6 (x) a description of any state or federal court order, including a conciliation court
467.7 judgment or a disciplinary order, related to the individual's occupational therapy practice;
467.8 and

467.9 (xi) a statement indicating the physical agent modalities the applicant will use and
467.10 whether the applicant will use the modalities as an occupational therapist or an occupational
467.11 therapy assistant under direct supervision;

467.12 (2) submit with the application all fees required by section 148.6445;

467.13 (3) sign a statement that the information in the application is true and correct to the best
467.14 of the applicant's knowledge and belief;

467.15 (4) sign a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's
467.16 records in this or any other state in which the applicant holds or previously held a credential
467.17 for the practice of an occupation, has completed an accredited occupational therapy education
467.18 program, or engaged in the practice of occupational therapy;

467.19 (5) submit additional information as requested by the ~~commissioner~~ board; and

467.20 (6) submit the additional information required for licensure by equivalency, licensure
467.21 by reciprocity, and temporary licensure as specified in sections 148.6408 to 148.6418.

467.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

467.23 Sec. 18. Minnesota Statutes 2016, section 148.6420, subdivision 3, is amended to read:

467.24 Subd. 3. **Applicants certified by National Board for Certification in Occupational**
467.25 **Therapy.** An applicant who is certified by the National Board for Certification in
467.26 Occupational Therapy must provide the materials required in subdivision 1 and the following:

467.27 (1) verified documentation from the National Board for Certification in Occupational
467.28 Therapy stating that the applicant is certified as an occupational therapist, registered or
467.29 certified occupational therapy assistant, the date certification was granted, and the applicant's
467.30 certification number. The document must also include a statement regarding disciplinary
467.31 actions. The applicant is responsible for obtaining this documentation by sending a form

468.1 provided by the ~~commissioner~~ board to the National Board for Certification in Occupational
468.2 Therapy; and

468.3 (2) a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's
468.4 records maintained by the National Board for Certification in Occupational Therapy.

468.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

468.6 Sec. 19. Minnesota Statutes 2016, section 148.6420, subdivision 5, is amended to read:

468.7 Subd. 5. **Action on applications for licensure.** (a) The ~~commissioner~~ board shall
468.8 approve, approve with conditions, or deny licensure. The ~~commissioner~~ board shall act on
468.9 an application for licensure according to paragraphs (b) to (d).

468.10 (b) The ~~commissioner~~ board shall determine if the applicant meets the requirements for
468.11 licensure. The ~~commissioner~~ board, or the advisory council at the ~~commissioner's~~ board's
468.12 request, may investigate information provided by an applicant to determine whether the
468.13 information is accurate and complete.

468.14 (c) The ~~commissioner~~ board shall notify an applicant of action taken on the application
468.15 and, if licensure is denied or approved with conditions, the grounds for the ~~commissioner's~~
468.16 board's determination.

468.17 (d) An applicant denied licensure or granted licensure with conditions may make a
468.18 written request to the ~~commissioner~~ board, within 30 days of the date of the ~~commissioner's~~
468.19 board's determination, for reconsideration of the ~~commissioner's~~ board's determination.
468.20 Individuals requesting reconsideration may submit information which the applicant wants
468.21 considered in the reconsideration. After reconsideration of the ~~commissioner's~~ board's
468.22 determination to deny licensure or grant licensure with conditions, the ~~commissioner~~ board
468.23 shall determine whether the original determination should be affirmed or modified. An
468.24 applicant is allowed no more than one request in any one biennial licensure period for
468.25 reconsideration of the ~~commissioner's~~ board's determination to deny licensure or approve
468.26 licensure with conditions.

468.27 **EFFECTIVE DATE.** This section is effective January 1, 2018.

468.28 Sec. 20. Minnesota Statutes 2016, section 148.6423, is amended to read:

468.29 **148.6423 LICENSURE RENEWAL.**

468.30 Subdivision 1. **Renewal requirements.** To be eligible for licensure renewal, a licensee
468.31 must:

469.1 (1) submit a completed and signed application for licensure renewal on forms provided
469.2 by the ~~commissioner~~ board;

469.3 (2) submit the renewal fee required under section 148.6445;

469.4 (3) submit proof of having met the continuing education requirement of section 148.6443
469.5 on forms provided by the ~~commissioner~~ board; and

469.6 (4) submit additional information as requested by the ~~commissioner~~ board to clarify
469.7 information presented in the renewal application. The information must be submitted within
469.8 30 days after the ~~commissioner's~~ board's request.

469.9 Subd. 2. **Renewal deadline.** (a) Except as provided in paragraph (c), licenses must be
469.10 renewed every two years. Licensees must comply with the following procedures in paragraphs
469.11 (b) to (e):

469.12 (b) Each license must state an expiration date. An application for licensure renewal must
469.13 be received by the ~~Department of Health~~ board or postmarked at least 30 calendar days
469.14 before the expiration date. If the postmark is illegible, the application shall be considered
469.15 timely if received at least 21 calendar days before the expiration date.

469.16 (c) If the ~~commissioner~~ board changes the renewal schedule and the expiration date is
469.17 less than two years, the fee and the continuing education contact hours to be reported at the
469.18 next renewal must be prorated.

469.19 (d) An application for licensure renewal not received within the time required under
469.20 paragraph (b), but received on or before the expiration date, must be accompanied by a late
469.21 fee in addition to the renewal fee specified by section 148.6445.

469.22 (e) Licensure renewals received after the expiration date shall not be accepted and persons
469.23 seeking licensed status must comply with the requirements of section 148.6425.

469.24 Subd. 3. **Licensure renewal notice.** At least 60 calendar days before the expiration date
469.25 in subdivision 2, the ~~commissioner~~ board shall mail a renewal notice to the licensee's last
469.26 known address on file with the ~~commissioner~~ board. The notice must include an application
469.27 for licensure renewal and notice of fees required for renewal. The licensee's failure to receive
469.28 notice does not relieve the licensee of the obligation to meet the renewal deadline and other
469.29 requirements for licensure renewal.

469.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

470.1 Sec. 21. Minnesota Statutes 2016, section 148.6425, subdivision 2, is amended to read:

470.2 Subd. 2. **Licensure renewal after licensure expiration date.** An individual whose
470.3 application for licensure renewal is received after the licensure expiration date must submit
470.4 the following:

470.5 (1) a completed and signed application for licensure following lapse in licensed status
470.6 on forms provided by the ~~commissioner~~ board;

470.7 (2) the renewal fee and the late fee required under section 148.6445;

470.8 (3) proof of having met the continuing education requirements in section 148.6443,
470.9 subdivision 1; and

470.10 (4) additional information as requested by the ~~commissioner~~ board to clarify information
470.11 in the application, including information to determine whether the individual has engaged
470.12 in conduct warranting disciplinary action as set forth in section 148.6448. The information
470.13 must be submitted within 30 days after the ~~commissioner's~~ board's request.

470.14 **EFFECTIVE DATE.** This section is effective January 1, 2018.

470.15 Sec. 22. Minnesota Statutes 2016, section 148.6425, subdivision 3, is amended to read:

470.16 Subd. 3. **Licensure renewal four years or more after licensure expiration date.** (a)
470.17 An individual who requests licensure renewal four years or more after the licensure expiration
470.18 date must submit the following:

470.19 (1) a completed and signed application for licensure on forms provided by the
470.20 ~~commissioner~~ board;

470.21 (2) the renewal fee and the late fee required under section 148.6445 if renewal application
470.22 is based on paragraph (b), clause (1), (2), or (3), or the renewal fee required under section
470.23 148.6445 if renewal application is based on paragraph (b), clause (4);

470.24 (3) proof of having met the continuing education requirement in section 148.6443,
470.25 subdivision 1, except the continuing education must be obtained in the two years immediately
470.26 preceding application renewal; and

470.27 (4) at the time of the next licensure renewal, proof of having met the continuing education
470.28 requirement, which shall be prorated based on the number of months licensed during the
470.29 two-year licensure period.

470.30 (b) In addition to the requirements in paragraph (a), the applicant must submit proof of
470.31 one of the following:

471.1 (1) verified documentation of successful completion of 160 hours of supervised practice
471.2 approved by the ~~commissioner~~ board as described in paragraph (c);

471.3 (2) verified documentation of having achieved a qualifying score on the credentialing
471.4 examination for occupational therapists or the credentialing examination for occupational
471.5 therapy assistants administered within the past year;

471.6 (3) documentation of having completed a combination of occupational therapy courses
471.7 or an occupational therapy refresher program that contains both a theoretical and clinical
471.8 component approved by the ~~commissioner~~ board. Only courses completed within one year
471.9 preceding the date of the application or one year after the date of the application qualify for
471.10 approval; or

471.11 (4) evidence that the applicant holds a current and unrestricted credential for the practice
471.12 of occupational therapy in another jurisdiction and that the applicant's credential from that
471.13 jurisdiction has been held in good standing during the period of lapse.

471.14 (c) To participate in a supervised practice as described in paragraph (b), clause (1), the
471.15 applicant shall obtain limited licensure. To apply for limited licensure, the applicant shall
471.16 submit the completed limited licensure application, fees, and agreement for supervision of
471.17 an occupational therapist or occupational therapy assistant practicing under limited licensure
471.18 signed by the supervising therapist and the applicant. The supervising occupational therapist
471.19 shall state the proposed level of supervision on the supervision agreement form provided
471.20 by the ~~commissioner~~ board. The supervising therapist shall determine the frequency and
471.21 manner of supervision based on the condition of the patient or client, the complexity of the
471.22 procedure, and the proficiencies of the supervised occupational therapist. At a minimum, a
471.23 supervising occupational therapist shall be on the premises at all times that the person
471.24 practicing under limited licensure is working; be in the room ten percent of the hours worked
471.25 each week by the person practicing under limited licensure; and provide daily face-to-face
471.26 collaboration for the purpose of observing service competency of the occupational therapist
471.27 or occupational therapy assistant, discussing treatment procedures and each client's response
471.28 to treatment, and reviewing and modifying, as necessary, each treatment plan. The supervising
471.29 therapist shall document the supervision provided. The occupational therapist participating
471.30 in a supervised practice is responsible for obtaining the supervision required under this
471.31 paragraph and must comply with the ~~commissioner's~~ board's requirements for supervision
471.32 during the entire 160 hours of supervised practice. The supervised practice must be completed
471.33 in two months and may be completed at the applicant's place of work.

472.1 (d) In addition to the requirements in paragraphs (a) and (b), the applicant must submit
472.2 additional information as requested by the ~~commissioner~~ board to clarify information in the
472.3 application, including information to determine whether the applicant has engaged in conduct
472.4 warranting disciplinary action as set forth in section 148.6448. The information must be
472.5 submitted within 30 days after the ~~commissioner's~~ board's request.

472.6 **EFFECTIVE DATE.** This section is effective January 1, 2018.

472.7 Sec. 23. Minnesota Statutes 2016, section 148.6428, is amended to read:

472.8 **148.6428 CHANGE OF NAME, ADDRESS, OR EMPLOYMENT.**

472.9 A licensee who changes a name, address, or employment must inform the ~~commissioner~~
472.10 board, in writing, of the change of name, address, employment, business address, or business
472.11 telephone number within 30 days. A change in name must be accompanied by a copy of a
472.12 marriage certificate or court order. All notices or other correspondence mailed to or served
472.13 on a licensee by the ~~commissioner~~ board at the licensee's address on file with the
472.14 ~~commissioner~~ board shall be considered as having been received by the licensee.

472.15 **EFFECTIVE DATE.** This section is effective January 1, 2018.

472.16 Sec. 24. Minnesota Statutes 2016, section 148.6443, subdivision 5, is amended to read:

472.17 Subd. 5. **Reporting continuing education contact hours.** Within one month following
472.18 licensure expiration, each licensee shall submit verification that the licensee has met the
472.19 continuing education requirements of this section on the continuing education report form
472.20 provided by the ~~commissioner~~ board. The continuing education report form may require
472.21 the following information:

472.22 (1) title of continuing education activity;

472.23 (2) brief description of the continuing education activity;

472.24 (3) sponsor, presenter, or author;

472.25 (4) location and attendance dates;

472.26 (5) number of contact hours; and

472.27 (6) licensee's notarized affirmation that the information is true and correct.

472.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

473.1 Sec. 25. Minnesota Statutes 2016, section 148.6443, subdivision 6, is amended to read:

473.2 Subd. 6. **Auditing continuing education reports.** (a) The ~~commissioner~~ board may
473.3 audit a percentage of the continuing education reports based on random selection. A licensee
473.4 shall maintain all documentation required by this section for two years after the last day of
473.5 the biennial licensure period in which the contact hours were earned.

473.6 (b) All renewal applications that are received after the expiration date may be subject
473.7 to a continuing education report audit.

473.8 (c) Any licensee against whom a complaint is filed may be subject to a continuing
473.9 education report audit.

473.10 (d) The licensee shall make the following information available to the ~~commissioner~~
473.11 board for auditing purposes:

473.12 (1) a copy of the completed continuing education report form for the continuing education
473.13 reporting period that is the subject of the audit including all supporting documentation
473.14 required by subdivision 5;

473.15 (2) a description of the continuing education activity prepared by the presenter or sponsor
473.16 that includes the course title or subject matter, date, place, number of program contact hours,
473.17 presenters, and sponsors;

473.18 (3) documentation of self-study programs by materials prepared by the presenter or
473.19 sponsor that includes the course title, course description, name of sponsor or author, and
473.20 the number of hours required to complete the program;

473.21 (4) documentation of university, college, or vocational school courses by a course
473.22 syllabus, listing in a course bulletin, or equivalent documentation that includes the course
473.23 title, instructor's name, course dates, number of contact hours, and course content, objectives,
473.24 or goals; and

473.25 (5) verification of attendance by:

473.26 (i) a signature of the presenter or a designee at the continuing education activity on the
473.27 continuing education report form or a certificate of attendance with the course name, course
473.28 date, and licensee's name;

473.29 (ii) a summary or outline of the educational content of an audio or video educational
473.30 activity to verify the licensee's participation in the activity if a designee is not available to
473.31 sign the continuing education report form;

474.1 (iii) verification of self-study programs by a certificate of completion or other
474.2 documentation indicating that the individual has demonstrated knowledge and has
474.3 successfully completed the program; or

474.4 (iv) verification of attendance at a university, college, or vocational course by an official
474.5 transcript.

474.6 **EFFECTIVE DATE.** This section is effective January 1, 2018.

474.7 Sec. 26. Minnesota Statutes 2016, section 148.6443, subdivision 7, is amended to read:

474.8 Subd. 7. **Waiver of continuing education requirements.** The ~~commissioner~~ board may
474.9 grant a waiver of the requirements of this section in cases where the requirements would
474.10 impose an extreme hardship on the licensee. The request for a waiver must be in writing,
474.11 state the circumstances that constitute extreme hardship, state the period of time the licensee
474.12 wishes to have the continuing education requirement waived, and state the alternative
474.13 measures that will be taken if a waiver is granted. The ~~commissioner~~ board shall set forth,
474.14 in writing, the reasons for granting or denying the waiver. Waivers granted by the
474.15 ~~commissioner~~ board shall specify, in writing, the time limitation and required alternative
474.16 measures to be taken by the licensee. A request for waiver shall be denied if the ~~commissioner~~
474.17 board finds that the circumstances stated by the licensee do not support a claim of extreme
474.18 hardship, the requested time period for waiver is unreasonable, the alternative measures
474.19 proposed by the licensee are not equivalent to the continuing education activity being waived,
474.20 or the request for waiver is not submitted to the ~~commissioner~~ board within 60 days after
474.21 the expiration date.

474.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

474.23 Sec. 27. Minnesota Statutes 2016, section 148.6443, subdivision 8, is amended to read:

474.24 Subd. 8. **Penalties for noncompliance.** The ~~commissioner~~ board shall refuse to renew
474.25 or grant, or shall suspend, condition, limit, or qualify the license of any person who the
474.26 ~~commissioner~~ board determines has failed to comply with the continuing education
474.27 requirements of this section. A licensee may request reconsideration of the ~~commissioner's~~
474.28 board's determination of noncompliance or the penalty imposed under this section by making
474.29 a written request to the ~~commissioner~~ board within 30 days of the date of notification to the
474.30 applicant. Individuals requesting reconsideration may submit information that the licensee
474.31 wants considered in the reconsideration.

474.32 **EFFECTIVE DATE.** This section is effective January 1, 2018.

475.1 Sec. 28. Minnesota Statutes 2016, section 148.6445, subdivision 1, is amended to read:

475.2 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists
 475.3 is \$145. The initial licensure fee for occupational therapy assistants is \$80. The ~~commissioner~~
 475.4 board shall prorate fees based on the number of quarters remaining in the biennial licensure
 475.5 period.

475.6 **EFFECTIVE DATE.** This section is effective January 1, 2018.

475.7 Sec. 29. Minnesota Statutes 2016, section 148.6445, subdivision 10, is amended to read:

475.8 Subd. 10. **Use of fees.** All fees are nonrefundable. The ~~commissioner~~ board shall only
 475.9 use fees collected under this section for the purposes of administering this chapter. The
 475.10 legislature must not transfer money generated by these fees from the state government
 475.11 special revenue fund to the general fund. ~~Surcharges collected by the commissioner of health~~
 475.12 ~~under section 16E.22 are not subject to this subdivision.~~

475.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

475.14 Sec. 30. Minnesota Statutes 2016, section 148.6448, is amended to read:

475.15 **148.6448 GROUNDS FOR DENIAL OF LICENSURE OR DISCIPLINE;**
 475.16 **INVESTIGATION PROCEDURES; DISCIPLINARY ACTIONS.**

475.17 Subdivision 1. **Grounds for denial of licensure or discipline.** The ~~commissioner~~ board
 475.18 may deny an application for licensure, may approve licensure with conditions, or may
 475.19 discipline a licensee using any disciplinary actions listed in subdivision 3 on proof that the
 475.20 individual has:

475.21 (1) intentionally submitted false or misleading information to the ~~commissioner~~ board
 475.22 or the advisory council;

475.23 (2) failed, within 30 days, to provide information in response to a written request by the
 475.24 ~~commissioner~~ board or advisory council;

475.25 (3) performed services of an occupational therapist or occupational therapy assistant in
 475.26 an incompetent manner or in a manner that falls below the community standard of care;

475.27 (4) failed to satisfactorily perform occupational therapy services during a period of
 475.28 temporary licensure;

475.29 (5) violated sections 148.6401 to ~~148.6450~~ 148.6449;

- 476.1 (6) failed to perform services with reasonable judgment, skill, or safety due to the use
476.2 of alcohol or drugs, or other physical or mental impairment;
- 476.3 (7) been convicted of violating any state or federal law, rule, or regulation which directly
476.4 relates to the practice of occupational therapy;
- 476.5 (8) aided or abetted another person in violating any provision of sections 148.6401 to
476.6 ~~148.6450~~ 148.6449;
- 476.7 (9) been disciplined for conduct in the practice of an occupation by the state of Minnesota,
476.8 another jurisdiction, or a national professional association, if any of the grounds for discipline
476.9 are the same or substantially equivalent to those in sections 148.6401 to ~~148.6450~~ 148.6449;
- 476.10 (10) not cooperated with the ~~commissioner or advisory council~~ board in an investigation
476.11 conducted according to subdivision 2;
- 476.12 (11) advertised in a manner that is false or misleading;
- 476.13 (12) engaged in dishonest, unethical, or unprofessional conduct in connection with the
476.14 practice of occupational therapy that is likely to deceive, defraud, or harm the public;
- 476.15 (13) demonstrated a willful or careless disregard for the health, welfare, or safety of a
476.16 client;
- 476.17 (14) performed medical diagnosis or provided treatment, other than occupational therapy,
476.18 without being licensed to do so under the laws of this state;
- 476.19 (15) paid or promised to pay a commission or part of a fee to any person who contacts
476.20 the occupational therapist for consultation or sends patients to the occupational therapist
476.21 for treatment;
- 476.22 (16) engaged in an incentive payment arrangement, other than that prohibited by clause
476.23 (15), that promotes occupational therapy overutilization, whereby the referring person or
476.24 person who controls the availability of occupational therapy services to a client profits
476.25 unreasonably as a result of client treatment;
- 476.26 (17) engaged in abusive or fraudulent billing practices, including violations of federal
476.27 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical
476.28 assistance laws;
- 476.29 (18) obtained money, property, or services from a consumer through the use of undue
476.30 influence, high pressure sales tactics, harassment, duress, deception, or fraud;
- 476.31 (19) performed services for a client who had no possibility of benefiting from the services;

477.1 (20) failed to refer a client for medical evaluation when appropriate or when a client
477.2 indicated symptoms associated with diseases that could be medically or surgically treated;

477.3 (21) engaged in conduct with a client that is sexual or may reasonably be interpreted by
477.4 the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a
477.5 patient;

477.6 (22) violated a federal or state court order, including a conciliation court judgment, or
477.7 a disciplinary order issued by the ~~commissioner~~ board, related to the person's occupational
477.8 therapy practice; or

477.9 (23) any other just cause related to the practice of occupational therapy.

477.10 Subd. 2. **Investigation of complaints.** The ~~commissioner~~, or the advisory council when
477.11 ~~authorized by the commissioner~~, board may initiate an investigation upon receiving a
477.12 complaint or other oral or written communication that alleges or implies that a person has
477.13 violated sections 148.6401 to ~~148.6450~~ 148.6449. In the receipt, investigation, and hearing
477.14 of a complaint that alleges or implies a person has violated sections 148.6401 to ~~148.6450~~
477.15 148.6449, the ~~commissioner~~ board shall follow the procedures in section 214.10.

477.16 Subd. 3. **Disciplinary actions.** If the ~~commissioner~~ board finds that an occupational
477.17 therapist or occupational therapy assistant should be disciplined according to subdivision
477.18 1, the ~~commissioner~~ board may take any one or more of the following actions:

477.19 (1) refuse to grant or renew licensure;

477.20 (2) approve licensure with conditions;

477.21 (3) revoke licensure;

477.22 (4) suspend licensure;

477.23 (5) any reasonable lesser action including, but not limited to, reprimand or restriction
477.24 on licensure; or

477.25 (6) any action authorized by statute.

477.26 Subd. 4. **Effect of specific disciplinary action on use of title.** Upon notice from the
477.27 ~~commissioner~~ board denying licensure renewal or upon notice that disciplinary actions have
477.28 been imposed and the person is no longer entitled to practice occupational therapy and use
477.29 the occupational therapy and licensed titles, the person shall cease to practice occupational
477.30 therapy, to use titles protected by sections 148.6401 to ~~148.6450~~ 148.6449, and to represent
477.31 to the public that the person is licensed by the ~~commissioner~~ board.

478.1 Subd. 5. **Reinstatement requirements after disciplinary action.** A person who has
478.2 had licensure suspended may request and provide justification for reinstatement following
478.3 the period of suspension specified by the ~~commissioner~~ board. The requirements of sections
478.4 148.6423 and 148.6425 for renewing licensure and any other conditions imposed with the
478.5 suspension must be met before licensure may be reinstated.

478.6 Subd. 6. **Authority to contract.** The ~~commissioner~~ board shall contract with the health
478.7 professionals services program as authorized by sections 214.31 to 214.37 to provide these
478.8 services to practitioners under this chapter. The health professionals services program does
478.9 not affect the ~~commissioner's board's~~ authority to discipline violations of sections 148.6401
478.10 to ~~148.6450~~ 148.6449.

478.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

478.12 Sec. 31. **[148.6449] BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

478.13 **Subdivision 1. Creation.** The Board of Occupational Therapy Practice consists of 11
478.14 members appointed by the governor. The members are:

478.15 (1) five occupational therapists licensed under sections 148.6401 to 148.6449;

478.16 (2) three occupational therapy assistants licensed under sections 148.6401 to 148.6449;

478.17 and

478.18 (3) three public members, including two members who have received occupational
478.19 therapy services or have a family member who has received occupational therapy services,
478.20 and one member who is a health care professional or health care provider licensed in
478.21 Minnesota.

478.22 **Subd. 2. Qualifications of board members.** (a) The occupational therapy practitioners
478.23 appointed to the board must represent a variety of practice areas and settings.

478.24 (b) At least two occupational therapy practitioners must be employed outside the
478.25 seven-county metropolitan area.

478.26 (c) Board members shall serve for not more than two consecutive terms.

478.27 **Subd. 3. Recommendations for appointment.** Prior to the end of the term of a member
478.28 of the board, or within 60 days after a position on the board becomes vacant, the Minnesota
478.29 Occupational Therapy Association and other interested persons and organizations may
478.30 recommend to the governor members qualified to serve on the board. The governor may
478.31 appoint members to the board from the list of persons recommended or from among other
478.32 qualified candidates.

479.1 Subd. 4. **Officers.** The board shall biennially elect from its membership a chair, vice-chair,
479.2 and secretary-treasurer. Each officer shall serve until a successor is elected.

479.3 Subd. 5. **Executive director.** The board shall appoint and employ an executive director
479.4 who is not a member of the board. The employment of the executive director shall be subject
479.5 to the terms described in section 214.04, subdivision 2a.

479.6 Subd. 6. **Terms; compensation; removal of members.** Membership terms, compensation
479.7 of members, removal of members, the filling of membership vacancies, and fiscal year and
479.8 reporting requirements shall be as provided in chapter 214. The provision of staff,
479.9 administrative services, and office space; the review and processing of complaints; the
479.10 setting of board fees; and other activities relating to board operations shall be conducted
479.11 according to chapter 214.

479.12 Subd. 7. **Duties of the Board of Occupational Therapy Practice.** (a) The board shall:

479.13 (1) adopt and enforce rules and laws necessary for licensing occupational therapy
479.14 practitioners;

479.15 (2) adopt and enforce rules for regulating the professional conduct of the practice of
479.16 occupational therapy;

479.17 (3) issue licenses to qualified individuals in accordance with sections 148.6401 to
479.18 148.6449;

479.19 (4) assess and collect fees for the issuance and renewal of licenses;

479.20 (5) educate the public about the requirements for licensing occupational therapy
479.21 practitioners, educate occupational therapy practitioners about the rules of conduct, and
479.22 enable the public to file complaints against applicants and licensees who may have violated
479.23 sections 148.6401 to 148.6449; and

479.24 (6) investigate individuals engaging in practices that violate sections 148.6401 to
479.25 148.6449 and take necessary disciplinary, corrective, or other action according to section
479.26 148.6448.

479.27 (b) The board may adopt rules necessary to define standards or carry out the provisions
479.28 of sections 148.6401 to 148.6449. Rules shall be adopted according to chapter 14.

479.29 **EFFECTIVE DATE.** This section is effective January 1, 2018.

479.30 Sec. 32. Minnesota Statutes 2016, section 148.881, is amended to read:

479.31 **148.881 DECLARATION OF POLICY.**

480.1 The practice of psychology in Minnesota affects the public health, safety, and welfare.
480.2 The regulations in ~~sections 148.88 to 148.98~~ the Minnesota Psychology Practice Act as
480.3 enforced by the Board of Psychology protect the public ~~from the practice of psychology by~~
480.4 ~~unqualified persons and from unethical or unprofessional conduct by persons licensed to~~
480.5 ~~practice psychology~~ through licensure and regulation to promote access to safe, ethical, and
480.6 competent psychological services.

480.7 Sec. 33. Minnesota Statutes 2016, section 148.89, is amended to read:

480.8 **148.89 DEFINITIONS.**

480.9 Subdivision 1. **Applicability.** For the purposes of sections 148.88 to 148.98, the following
480.10 terms have the meanings given them.

480.11 Subd. 2. **Board of Psychology or board.** "Board of Psychology" or "board" means the
480.12 board established under section 148.90.

480.13 Subd. 2a. **Client.** "Client" means ~~each individual or legal, religious, academic,~~
480.14 ~~organizational, business, governmental, or other entity that receives, received, or should~~
480.15 ~~have received, or arranged for another individual or entity to receive services from an~~
480.16 ~~individual regulated under sections 148.88 to 148.98. Client also means an individual's~~
480.17 ~~legally authorized representative, such as a parent or guardian. For the purposes of sections~~
480.18 ~~148.88 to 148.98, "client" may include patient, resident, counselee, evaluatee, and, as limited~~
480.19 ~~in the rules of conduct, student, supervisee, or research subject. In the case of dual clients,~~
480.20 ~~the licensee or applicant for licensure must be aware of the responsibilities to each client,~~
480.21 ~~and of the potential for divergent interests of each client~~ a direct recipient of psychological
480.22 services within the context of a professional relationship that may include a child, adolescent,
480.23 adult, couple, family, group, organization, community, or other entity. The client may be
480.24 the person requesting the psychological services or the direct recipient of the services.

480.25 Subd. 2b. **Credentialed.** "Credentialed" means having a license, certificate, charter,
480.26 registration, or similar authority to practice in an occupation regulated by a governmental
480.27 board or agency.

480.28 Subd. 2c. **Designated supervisor.** "Designated supervisor" means a qualified individual
480.29 who is ~~designated~~ identified and assigned by the primary supervisor to provide additional
480.30 supervision and training ~~to a licensed psychological practitioner or to an individual who is~~
480.31 ~~obtaining required predegree supervised professional experience or postdegree supervised~~
480.32 psychological employment.

481.1 Subd. 2d. **Direct services.** "Direct services" means the delivery of preventive, diagnostic,
 481.2 assessment, or therapeutic intervention services where the primary purpose is to benefit a
 481.3 client who is the direct recipient of the service.

481.4 Subd. 2e. **Full-time employment.** "Full-time employment" means a minimum of 35
 481.5 clock hours per week.

481.6 **Subd. 3. Independent practice.** "Independent practice" means the practice of psychology
 481.7 without supervision.

481.8 Subd. 3a. **Jurisdiction.** "Jurisdiction" means the United States, United States territories,
 481.9 or Canadian provinces or territories.

481.10 **Subd. 4. Licensee.** "Licensee" means a person who is licensed by the board as a licensed
 481.11 ~~psychologist or as a licensed psychological practitioner.~~

481.12 **Subd. 4a. Provider or provider of services.** "Provider" or "provider of services" means
 481.13 any individual who is regulated by the board, ~~and includes a licensed psychologist, a licensed~~
 481.14 ~~psychological practitioner, a licensee, or an applicant.~~

481.15 **Subd. 4b. Primary supervisor.** "Primary supervisor" means a psychologist licensed in
 481.16 Minnesota or other qualified individual who provides the principal supervision ~~to a licensed~~
 481.17 ~~psychological practitioner or to an individual who is obtaining required predegree supervised~~
 481.18 professional experience or postdegree supervised psychological employment.

481.19 **Subd. 5. Practice of psychology.** "Practice of psychology" means the observation,
 481.20 description, evaluation, interpretation, ~~or prediction,~~ or modification of human behavior by
 481.21 the application of psychological principles, methods, or procedures for ~~any reason, including~~
 481.22 ~~to prevent, eliminate, or manage~~ the purpose of preventing, eliminating, evaluating, assessing,
 481.23 or predicting symptomatic, maladaptive, or undesired behavior; applying psychological
 481.24 principles in legal settings; and to enhance enhancing interpersonal relationships, work, life
 481.25 and developmental adjustment, personal and organizational effectiveness, behavioral health,
 481.26 and mental health. The practice of psychology includes, but is not limited to, the following
 481.27 services, regardless of whether the provider receives payment for the services:

481.28 (1) psychological research and teaching of psychology subject to the exemptions in
 481.29 section 148.9075;

481.30 (2) ~~assessment, including psychological testing and other means of evaluating personal~~
 481.31 ~~characteristics such as intelligence, personality, abilities, interests, aptitudes, and~~
 481.32 ~~neuropsychological functioning~~ psychological testing and the evaluation or assessment of

482.1 personal characteristics, such as intelligence, personality, cognitive, physical and emotional
482.2 abilities, skills, interests, aptitudes, and neuropsychological functioning;

482.3 ~~(3) a psychological report, whether written or oral, including testimony of a provider as~~
482.4 ~~an expert witness, concerning the characteristics of an individual or entity~~ counseling,
482.5 psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy;

482.6 ~~(4) psychotherapy, including but not limited to, categories such as behavioral, cognitive,~~
482.7 ~~emotive, systems, psychophysiological, or insight-oriented therapies; counseling; hypnosis;~~
482.8 ~~and diagnosis and treatment of:~~

482.9 ~~(i) mental and emotional disorder or disability;~~

482.10 ~~(ii) alcohol and substance dependence or abuse;~~

482.11 ~~(iii) disorders of habit or conduct;~~

482.12 ~~(iv) the psychological aspects of physical illness or condition, accident, injury, or~~
482.13 ~~disability, including the psychological impact of medications;~~

482.14 ~~(v) life adjustment issues, including work-related and bereavement issues; and~~

482.15 ~~(vi) child, family, or relationship issues~~

482.16 (4) diagnosis, treatment, and management of mental or emotional disorders or disabilities,
482.17 substance use disorders, disorders of habit or conduct, and the psychological aspects of
482.18 physical illness, accident, injury, or disability;

482.19 ~~(5) psychoeducational services and treatment~~ psychoeducational evaluation, therapy,
482.20 and remediation; and

482.21 ~~(6) consultation and supervision~~ with physicians, other health care professionals, and
482.22 clients regarding available treatment options, including medication, with respect to the
482.23 provision of care for a specific client;

482.24 (7) provision of direct services to individuals or groups for the purpose of enhancing
482.25 individual and organizational effectiveness, using psychological principles, methods, and
482.26 procedures to assess and evaluate individuals on personal characteristics for individual
482.27 development or behavior change or for making decisions about the individual; and

482.28 (8) supervision and consultation related to any of the services described in this
482.29 subdivision.

483.1 Subd. 6. Telesupervision. "Telesupervision" means the clinical supervision of
 483.2 psychological services through a synchronous audio and video format where the supervisor
 483.3 is not physically in the same facility as the supervisee.

483.4 Sec. 34. Minnesota Statutes 2016, section 148.90, subdivision 1, is amended to read:

483.5 Subdivision 1. **Board of Psychology.** (a) The Board of Psychology is created with the
 483.6 powers and duties described in this section. The board has 11 members who consist of:

483.7 (1) ~~three~~ four individuals licensed as licensed psychologists who have doctoral degrees
 483.8 in psychology;

483.9 (2) two individuals licensed as licensed psychologists who have master's degrees in
 483.10 psychology;

483.11 (3) two psychologists, not necessarily licensed, ~~one with a~~ who have ~~doctoral degree~~
 483.12 degrees in psychology ~~and one with either a doctoral or master's degree in psychology~~
 483.13 representing different training programs in psychology;

483.14 ~~(4) one individual licensed or qualified to be licensed as: (i) through December 31, 2010,~~
 483.15 ~~a licensed psychological practitioner; and (ii) after December 31, 2010, a licensed~~
 483.16 ~~psychologist; and~~

483.17 ~~(5)~~ (4) three public members.

483.18 (b) After the date on which fewer than 30 percent of the individuals licensed by the
 483.19 board as licensed psychologists qualify for licensure under section 148.907, subdivision 3,
 483.20 paragraph (b), vacancies filled under paragraph (a), clause (2), shall be filled by an individual
 483.21 with either a master's or doctoral degree in psychology licensed or qualified to be licensed
 483.22 as a licensed psychologist.

483.23 (c) After the date on which fewer than 15 percent of the individuals licensed by the board
 483.24 as licensed psychologists qualify for licensure under section 148.907, subdivision 3,
 483.25 paragraph (b), vacancies under paragraph (a), clause (2), shall be filled by an individual
 483.26 with either a master's or doctoral degree in psychology licensed or qualified to be licensed
 483.27 as a licensed psychologist.

483.28 Sec. 35. Minnesota Statutes 2016, section 148.90, subdivision 2, is amended to read:

483.29 Subd. 2. **Members.** (a) The members of the board shall:

483.30 (1) be appointed by the governor;

483.31 (2) be residents of the state;

- 484.1 (3) serve for not more than two consecutive terms;
- 484.2 (4) designate the officers of the board; and
- 484.3 (5) administer oaths pertaining to the business of the board.
- 484.4 (b) A public member of the board shall represent the public interest and shall not:
- 484.5 (1) be a psychologist, ~~psychological practitioner~~, or have engaged in the practice of
- 484.6 psychology;
- 484.7 (2) be an applicant or former applicant for licensure;
- 484.8 (3) be a member of another health profession and be licensed by a health-related licensing
- 484.9 board as defined under section 214.01, subdivision 2; the commissioner of health; or licensed,
- 484.10 certified, or registered by another jurisdiction;
- 484.11 (4) be a member of a household that includes a psychologist ~~or psychological practitioner~~;
- 484.12 or
- 484.13 (5) have conflicts of interest or the appearance of conflicts with duties as a board member.
- 484.14 Sec. 36. Minnesota Statutes 2016, section 148.905, subdivision 1, is amended to read:
- 484.15 Subdivision 1. **General.** The board shall:
- 484.16 (1) adopt and enforce rules for licensing psychologists ~~and psychological practitioners~~
- 484.17 and for regulating their professional conduct;
- 484.18 (2) adopt and enforce rules of conduct governing the practice of psychology;
- 484.19 (3) adopt and implement rules for examinations which shall be held at least once a year
- 484.20 to assess applicants' knowledge and skills. The examinations may be written or oral or both,
- 484.21 and may be administered by the board or by institutions or individuals designated by the
- 484.22 board; Before the adoption and implementation of a new national examination, the board
- 484.23 must consider whether the examination:
- 484.24 (i) demonstrates reasonable reliability and external validity;
- 484.25 (ii) is normed on a reasonable representative and diverse national sample; and
- 484.26 (iii) is intended to assess an applicant's education, training, and experience for the purpose
- 484.27 of public protection;
- 484.28 (4) issue licenses to individuals qualified under sections 148.907 ~~and 148.908~~, 148.909,
- 484.29 148.915, and 148.916, according to the procedures for licensing in Minnesota Rules;
- 484.30 (5) issue copies of the rules for licensing to all applicants;

485.1 (6) establish and maintain annually a register of current licenses;

485.2 (7) establish and collect fees for the issuance and renewal of licenses and other services
 485.3 by the board. Fees shall be set to defray the cost of administering the provisions of sections
 485.4 148.88 to 148.98 including costs for applications, examinations, enforcement, materials,
 485.5 and the operations of the board;

485.6 (8) educate the public ~~about~~ on the requirements for ~~licensing of psychologists and of~~
 485.7 ~~psychological practitioners~~ licenses issued by the board and ~~about~~ on the rules of conduct;
 485.8 ~~to~~;

485.9 (9) enable the public to file complaints against applicants or licensees who may have
 485.10 violated the Psychology Practice Act; ~~and~~

485.11 ~~(9)~~ (10) adopt and implement requirements for continuing education; and

485.12 (11) establish or approve programs that qualify for professional psychology continuing
 485.13 educational credit. The board may hire consultants, agencies, or professional psychological
 485.14 associations to establish and approve continuing education courses.

485.15 Sec. 37. Minnesota Statutes 2016, section 148.907, subdivision 1, is amended to read:

485.16 Subdivision 1. **Effective date.** ~~After August 1, 1991,~~ No person shall engage in the
 485.17 independent practice of psychology unless that person is licensed as a licensed psychologist
 485.18 or is exempt under section 148.9075.

485.19 Sec. 38. Minnesota Statutes 2016, section 148.907, subdivision 2, is amended to read:

485.20 Subd. 2. **Requirements for licensure as licensed psychologist.** To become licensed
 485.21 by the board as a licensed psychologist, an applicant shall comply with the following
 485.22 requirements:

485.23 (1) pass an examination in psychology;

485.24 (2) pass a professional responsibility examination on the practice of psychology;

485.25 (3) pass any other examinations as required by board rules;

485.26 (4) pay nonrefundable fees to the board for applications, processing, testing, renewals,
 485.27 and materials;

485.28 (5) ~~have~~ attained the age of majority, be of good moral character, and have no unresolved
 485.29 disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction;

486.1 (6) ~~have~~ earned a doctoral degree with a major in psychology from a regionally accredited
486.2 educational institution meeting the standards the board has established by rule; and

486.3 (7) ~~have~~ completed at least one full year or the equivalent in part time of postdoctoral
486.4 supervised psychological employment in no less than 12 months and no more than 60
486.5 months. If the postdoctoral supervised psychological employment goes beyond 60 months,
486.6 the board may grant a variance to this requirement.

486.7 Sec. 39. [148.9075] EXEMPTIONS TO LICENSE REQUIREMENT.

486.8 Subdivision 1. **General.** (a) Nothing in sections 148.88 to 148.98 shall prevent members
486.9 of other professions or occupations from performing functions for which they are competent
486.10 and properly authorized by law. The following individuals are exempt from the licensure
486.11 requirements of the Minnesota Psychology Practice Act, provided they operate in compliance
486.12 with the stated exemption:

486.13 (1) individuals licensed by a health-related licensing board as defined under section
486.14 214.01, subdivision 2, or by the commissioner of health;

486.15 (2) individuals authorized as mental health practitioners as defined under section 245.462,
486.16 subdivision 17; and

486.17 (3) individuals authorized as mental health professionals under section 245.462,
486.18 subdivision 18.

486.19 (b) Any of these individuals must not hold themselves out to the public by any title or
486.20 description stating or implying they are licensed to engage in the practice of psychology
486.21 unless they are licensed under sections 148.88 to 148.98 or are using a title in compliance
486.22 with section 148.96.

486.23 Subd. 2. **Business or industrial organization.** Nothing in sections 148.88 to 148.98
486.24 shall prevent the use of psychological techniques by a business or industrial organization
486.25 for its own personnel purposes or by an employment agency or state vocational rehabilitation
486.26 agency for the evaluation of the agency's clients prior to a recommendation for employment.
486.27 However, a representative of an industrial or business firm or corporation may not sell,
486.28 offer, or provide psychological services as specified in section 148.89, unless the services
486.29 are performed or supervised by an individual licensed under sections 148.88 to 148.98.

486.30 Subd. 3. **School psychologist.** (a) Nothing in sections 148.88 to 148.98 shall be construed
486.31 to prevent a person who holds a license or certificate issued by the State Board of Teaching
486.32 in accordance with chapters 122A and 129 from practicing school psychology within the
486.33 scope of employment if authorized by a board of education or by a private school that meets

487.1 the standards prescribed by the State Board of Teaching, or from practicing as a school
487.2 psychologist within the scope of employment in a program for children with disabilities.

487.3 (b) Any person exempted under this subdivision shall not offer psychological services
487.4 to any other individual, organization, or group for remuneration, monetary or otherwise,
487.5 unless the person is licensed by the Board of Psychology under sections 148.88 to 148.98.

487.6 Subd. 4. **Clergy or religious officials.** Nothing in sections 148.88 to 148.98 shall be
487.7 construed to prevent recognized religious officials, including ministers, priests, rabbis,
487.8 imams, Christian Science practitioners, and other persons recognized by the board, from
487.9 conducting counseling activities that are within the scope of the performance of their regular
487.10 recognizable religious denomination or sect, as defined in current federal tax regulations,
487.11 if the religious official does not refer to the official's self as a psychologist and the official
487.12 remains accountable to the established authority of the religious denomination or sect.

487.13 Subd. 5. **Teaching and research.** Nothing in sections 148.88 to 148.98 shall be construed
487.14 to prevent a person employed in a secondary, postsecondary, or graduate institution from
487.15 teaching and conducting research in psychology within an educational institution that is
487.16 recognized by a regional accrediting organization or by a federal, state, county, or local
487.17 government institution, agency, or research facility, so long as:

487.18 (1) the institution, agency, or facility provides appropriate oversight mechanisms to
487.19 ensure public protections; and

487.20 (2) the person is not providing direct clinical services to a client or clients as defined in
487.21 sections 148.88 to 148.98.

487.22 Subd. 6. **Psychologist in disaster or emergency relief.** Nothing in sections 148.88 to
487.23 148.98 shall be construed to prevent a psychologist sent to this state for the sole purpose of
487.24 responding to a disaster or emergency relief effort of the state government, the federal
487.25 government, the American Red Cross, or other disaster or emergency relief organization as
487.26 long as the psychologist is not practicing in Minnesota longer than 30 days and the sponsoring
487.27 organization can certify the psychologist's assignment to this state. The board or its designee,
487.28 at its discretion, may grant an extension to the 30-day time limitation of this subdivision.

487.29 Subd. 7. **Psychological consultant.** A license under sections 148.88 to 148.98 is not
487.30 required by a nonresident of the state, serving as an expert witness, organizational consultant,
487.31 presenter, or educator on a limited basis provided the person is appropriately trained,
487.32 educated, or has been issued a license, certificate, or registration by another jurisdiction.

488.1 Subd. 8. **Students.** Nothing in sections 148.88 to 148.98 shall prohibit the practice of
488.2 psychology under qualified supervision by a practicum psychology student, a predoctoral
488.3 psychology intern, or an individual who has earned a doctoral degree in psychology and is
488.4 in the process of completing their postdoctoral supervised psychological employment. A
488.5 student trainee or intern shall use the titles as required under section 148.96, subdivision 3.

488.6 Subd. 9. **Other professions.** Nothing in sections 148.88 to 148.98 shall be construed to
488.7 authorize a person licensed under sections 148.88 to 148.98 to engage in the practice of any
488.8 profession regulated under Minnesota law, unless the individual is duly licensed or registered
488.9 in that profession.

488.10 Sec. 40. [148.9077] RELICENSURE.

488.11 A former licensee may apply to the board for licensure after complying with all laws
488.12 and rules required for applicants for licensure that were in effect on the date the initial
488.13 Minnesota license was granted. The former licensee must verify to the board that the former
488.14 licensee has not engaged in the practice of psychology in this state since the last date of
488.15 active licensure, except as permitted under statutory licensure exemption, and must submit
488.16 a fee for relicensure.

488.17 Sec. 41. Minnesota Statutes 2016, section 148.9105, subdivision 1, is amended to read:

488.18 Subdivision 1. **Application.** Retired providers who are licensed or were formerly licensed
488.19 to practice psychology in the state according to the Minnesota Psychology Practice Act may
488.20 apply to the board for psychologist emeritus registration ~~or psychological practitioner~~
488.21 ~~emeritus registration~~ if they declare that they are retired from the practice of psychology in
488.22 Minnesota, have not been the subject of disciplinary action in any jurisdiction, and have no
488.23 unresolved complaints in any jurisdiction. Retired providers shall complete the necessary
488.24 forms provided by the board and pay a onetime, nonrefundable fee of \$150 at the time of
488.25 application.

488.26 Sec. 42. Minnesota Statutes 2016, section 148.9105, subdivision 4, is amended to read:

488.27 Subd. 4. **Documentation of status.** A provider granted emeritus registration shall receive
488.28 a document certifying that emeritus status has been granted by the board and that the
488.29 registrant has completed the registrant's active career as a psychologist ~~or psychological~~
488.30 ~~practitioner~~ licensed in good standing with the board.

489.1 Sec. 43. Minnesota Statutes 2016, section 148.9105, subdivision 5, is amended to read:

489.2 Subd. 5. **Representation to public.** In addition to the descriptions allowed in section
489.3 148.96, subdivision 3, paragraph (e), former licensees who have been granted emeritus
489.4 registration may represent themselves as "psychologist emeritus" or "~~psychological~~
489.5 ~~practitioner emeritus,~~" but shall not represent themselves or allow themselves to be
489.6 represented to the public as "licensed" or otherwise as current licensees of the board.

489.7 Sec. 44. Minnesota Statutes 2016, section 148.916, subdivision 1, is amended to read:

489.8 Subdivision 1. **Generally.** ~~If (a)~~ A nonresident of the state of Minnesota, who is not
489.9 seeking licensure in this state, and who has been issued a license, certificate, or registration
489.10 by another jurisdiction to practice psychology ~~at the doctoral level, wishes and who intends~~
489.11 to practice in Minnesota for more than ~~seven calendar~~ 30 days, ~~the person~~ shall apply to the
489.12 board for guest licensure, ~~provided that~~. The psychologist's practice in Minnesota is limited
489.13 to no more than nine consecutive months per calendar year. Application under this section
489.14 shall be made no less than 30 days prior to the expected date of practice in Minnesota and
489.15 shall be subject to approval by the board or its designee. ~~The board shall charge a~~
489.16 ~~nonrefundable fee for guest licensure. The board shall adopt rules to implement this section.~~

489.17 (b) To be eligible for licensure under this section, the applicant must:

489.18 (1) have a license, certification, or registration to practice psychology from another
489.19 jurisdiction;

489.20 (2) have a doctoral degree in psychology from a regionally accredited institution;

489.21 (3) be of good moral character;

489.22 (4) have no pending complaints or active disciplinary or corrective actions in any
489.23 jurisdiction;

489.24 (5) pass a professional responsibility examination designated by the board; and

489.25 (6) pay a fee to the board.

489.26 Sec. 45. Minnesota Statutes 2016, section 148.916, subdivision 1a, is amended to read:

489.27 Subd. 1a. **Applicants for licensure.** (a) An applicant who is seeking licensure in this
489.28 state, and who, at the time of application, is licensed, certified, or registered to practice
489.29 psychology in another jurisdiction at the doctoral level may apply to the board for guest
489.30 licensure in order to begin practicing psychology in this state while their application is being

490.1 processed if the applicant is of good moral character and has no complaints, corrective, or
 490.2 disciplinary action pending in any jurisdiction.

490.3 (b) Application under this section subdivision shall be made no less than 30 days prior
 490.4 to the expected date of practice in this state, and must be made concurrently or after
 490.5 submission of an application for licensure as a licensed psychologist if applicable.
 490.6 Applications under this section subdivision are subject to approval by the board or its
 490.7 designee. The board shall charge a fee for guest licensure under this subdivision.

490.8 ~~(b) The board shall charge a nonrefundable fee for guest licensure under this subdivision.~~

490.9 (c) A guest license issued under this subdivision shall be valid for one year from the
 490.10 date of issuance, or until the board has either issued a license or has denied the applicant's
 490.11 application for licensure, whichever is earlier. Guest licenses issued under this section
 490.12 subdivision may be renewed annually until the board has denied the applicant's application
 490.13 for licensure.

490.14 Sec. 46. Minnesota Statutes 2016, section 148.925, is amended to read:

490.15 **148.925 SUPERVISION.**

490.16 Subdivision 1. **Supervision.** For the purpose of meeting the requirements of ~~this section~~
 490.17 the Minnesota Psychology Practice Act, supervision means documented in-person
 490.18 ~~consultation, which may include interactive, visual electronic communication, between~~
 490.19 ~~either: (1) a primary supervisor and a licensed psychological practitioner; or (2) a that~~
 490.20 employs a collaborative relationship that has both facilitative and evaluative components
 490.21 with the goal of enhancing the professional competence and science, and practice-informed
 490.22 professional work of the supervisee. Supervision may include telesupervision between
 490.23 primary or designated supervisor supervisors and an applicant for licensure as a licensed
 490.24 psychologist the supervisee. The supervision shall be adequate to assure the quality and
 490.25 competence of the activities supervised. Supervisory consultation shall include discussions
 490.26 on the nature and content of the practice of the supervisee, including, but not limited to, a
 490.27 review of a representative sample of psychological services in the supervisee's practice.

490.28 Subd. 2. **Postdegree supervised psychological employment.** Postdegree supervised
 490.29 psychological employment means required paid or volunteer work experience and postdegree
 490.30 training of an individual seeking to be licensed as a licensed psychologist that involves the
 490.31 professional oversight by a primary supervisor and satisfies the supervision requirements
 490.32 in subdivisions 3 and 5 the Minnesota Psychology Practice Act.

491.1 Subd. 3. **Individuals qualified to provide supervision.** ~~(a) Supervision of a master's~~
491.2 ~~level applicant for licensure as a licensed psychologist shall be provided by an individual:~~

491.3 ~~(1) who is a psychologist licensed in Minnesota with competence both in supervision~~
491.4 ~~in the practice of psychology and in the activities being supervised;~~

491.5 ~~(2) who has a doctoral degree with a major in psychology, who is employed by a~~
491.6 ~~regionally accredited educational institution or employed by a federal, state, county, or local~~
491.7 ~~government institution, agency, or research facility, and who has competence both in~~
491.8 ~~supervision in the practice of psychology and in the activities being supervised, provided~~
491.9 ~~the supervision is being provided and the activities being supervised occur within that~~
491.10 ~~regionally accredited educational institution or federal, state, county, or local government~~
491.11 ~~institution, agency, or research facility;~~

491.12 ~~(3) who is licensed or certified as a psychologist in another jurisdiction and who has~~
491.13 ~~competence both in supervision in the practice of psychology and in the activities being~~
491.14 ~~supervised; or~~

491.15 ~~(4) who, in the case of a designated supervisor, is a master's or doctorally prepared~~
491.16 ~~mental health professional.~~

491.17 ~~(b) Supervision of a doctoral level~~ an applicant for licensure as a licensed psychologist
491.18 shall be provided by an individual:

491.19 (1) who is a psychologist licensed in Minnesota with a doctoral degree and competence
491.20 both in supervision in the practice of psychology and in the activities being supervised;

491.21 (2) who has a doctoral degree with a major in psychology, who is employed by a
491.22 regionally accredited educational institution or is employed by a federal, state, county, or
491.23 local government institution, agency, or research facility, and who has competence both in
491.24 supervision in the practice of psychology and in the activities being supervised, provided
491.25 the supervision is being provided and the activities being supervised occur within that
491.26 regionally accredited educational institution or federal, state, county, or local government
491.27 institution, agency, or research facility;

491.28 (3) who is licensed or certified as a psychologist in another jurisdiction and who has
491.29 competence both in supervision in the practice of psychology and in the activities being
491.30 supervised;

491.31 (4) who is a psychologist licensed in Minnesota who was licensed before August 1,
491.32 1991, with competence both in supervision in the practice of psychology and in the activities
491.33 being supervised; or

492.1 (5) who, in the case of a designated supervisor, is a master's or doctorally prepared
492.2 mental health professional.

492.3 **Subd. 4. ~~Supervisory consultation for a licensed psychological practitioner.~~**

492.4 ~~Supervisory consultation between a supervising licensed psychologist and a supervised~~
492.5 ~~licensed psychological practitioner shall be at least one hour in duration and shall occur on~~
492.6 ~~an individual, in-person basis. A minimum of one hour of supervision per month is required~~
492.7 ~~for the initial 20 or fewer hours of psychological services delivered per month. For each~~
492.8 ~~additional 20 hours of psychological services delivered per month, an additional hour of~~
492.9 ~~supervision per month is required. When more than 20 hours of psychological services are~~
492.10 ~~provided in a week, no more than one hour of supervision is required per week.~~

492.11 **Subd. 5. Supervisory consultation for an applicant for licensure as a licensed**

492.12 **psychologist.** Supervision of an applicant for licensure as a licensed psychologist shall
492.13 include at least two hours of regularly scheduled in-person consultations per week for
492.14 full-time employment, one hour of which shall be with the supervisor on an individual basis.
492.15 The remaining hour may be with a designated supervisor. The board may approve an
492.16 exception to the weekly supervision requirement for a week when the supervisor was ill or
492.17 otherwise unable to provide supervision. The board may prorate the two hours per week of
492.18 supervision for individuals preparing for licensure on a part-time basis. Supervised
492.19 psychological employment does not qualify for licensure when the supervisory consultation
492.20 is not adequate as described in subdivision 1, or in the board rules.

492.21 **Subd. 6. Supervisee duties.** ~~Individuals~~ Applicants preparing for licensure as a licensed
492.22 psychologist during their postdegree supervised psychological employment may perform
492.23 as part of their training any ~~functions~~ of the services specified in section 148.89, subdivision
492.24 5, but only under qualified supervision.

492.25 **Subd. 7. ~~Variance from supervision requirements.~~** (a) ~~An applicant for licensure as~~
492.26 ~~a licensed psychologist who entered supervised employment before August 1, 1991, may~~
492.27 ~~request a variance from the board from the supervision requirements in this section in order~~
492.28 ~~to continue supervision under the board rules in effect before August 1, 1991.~~

492.29 (b) ~~After a licensed psychological practitioner has completed two full years, or the~~
492.30 ~~equivalent, of supervised post-master's degree employment meeting the requirements of~~
492.31 ~~subdivision 5 as it relates to preparation for licensure as a licensed psychologist, the board~~
492.32 ~~shall grant a variance from the supervision requirements of subdivision 4 or 5 if the licensed~~
492.33 ~~psychological practitioner presents evidence of:~~

493.1 ~~(1) endorsement for specific areas of competency by the licensed psychologist who~~
493.2 ~~provided the two years of supervision;~~

493.3 ~~(2) employment by a hospital or by a community mental health center or nonprofit mental~~
493.4 ~~health clinic or social service agency providing services as a part of the mental health service~~
493.5 ~~plan required by the Comprehensive Mental Health Act;~~

493.6 ~~(3) the employer's acceptance of clinical responsibility for the care provided by the~~
493.7 ~~licensed psychological practitioner; and~~

493.8 ~~(4) a plan for supervision that includes at least one hour of regularly scheduled individual~~
493.9 ~~in-person consultations per week for full-time employment. The board may approve an~~
493.10 ~~exception to the weekly supervision requirement for a week when the supervisor was ill or~~
493.11 ~~otherwise unable to provide supervision.~~

493.12 ~~(e) Following the granting of a variance under paragraph (b), and completion of two~~
493.13 ~~additional full years or the equivalent of supervision and post-master's degree employment~~
493.14 ~~meeting the requirements of paragraph (b), the board shall grant a variance to a licensed~~
493.15 ~~psychological practitioner who presents evidence of:~~

493.16 ~~(1) endorsement for specific areas of competency by the licensed psychologist who~~
493.17 ~~provided the two years of supervision under paragraph (b);~~

493.18 ~~(2) employment by a hospital or by a community mental health center or nonprofit mental~~
493.19 ~~health clinic or social service agency providing services as a part of the mental health service~~
493.20 ~~plan required by the Comprehensive Mental Health Act;~~

493.21 ~~(3) the employer's acceptance of clinical responsibility for the care provided by the~~
493.22 ~~licensed psychological practitioner; and~~

493.23 ~~(4) a plan for supervision which includes at least one hour of regularly scheduled~~
493.24 ~~individual in-person supervision per month.~~

493.25 ~~(d) The variance allowed under this section must be deemed to have been granted to an~~
493.26 ~~individual who previously received a variance under paragraph (b) or (c) and is seeking a~~
493.27 ~~new variance because of a change of employment to a different employer or employment~~
493.28 ~~setting. The deemed variance continues until the board either grants or denies the variance.~~
493.29 ~~An individual who has been denied a variance under this section is entitled to seek~~
493.30 ~~reconsideration by the board.~~

494.1 Sec. 47. Minnesota Statutes 2016, section 148.96, subdivision 3, is amended to read:

494.2 Subd. 3. **Requirements for representations to public.** (a) Unless licensed under sections
494.3 148.88 to 148.98, except as provided in paragraphs (b) through (e), persons shall not represent
494.4 themselves or permit themselves to be represented to the public by:

494.5 (1) using any title or description of services incorporating the words "psychology,"
494.6 "psychological," "psychological practitioner," or "psychologist"; or

494.7 (2) representing that the person has expert qualifications in an area of psychology.

494.8 (b) Psychologically trained individuals who are employed by an educational institution
494.9 recognized by a regional accrediting organization, by a federal, state, county, or local
494.10 government institution, agency, or research facility, may represent themselves by the title
494.11 designated by that organization provided that the title does not indicate that the individual
494.12 is credentialed by the board.

494.13 (c) A psychologically trained individual from an institution described in paragraph (b)
494.14 may offer lecture services and is exempt from the provisions of this section.

494.15 (d) A person who is preparing for the practice of psychology under supervision in
494.16 accordance with board statutes and rules may be designated as a "psychological intern,"
494.17 "psychology fellow," "psychological trainee," or by other terms clearly describing the
494.18 person's training status.

494.19 (e) Former licensees who are completely retired from the practice of psychology may
494.20 represent themselves using the descriptions in paragraph (a), clauses (1) and (2), but shall
494.21 not represent themselves or allow themselves to be represented as current licensees of the
494.22 board.

494.23 ~~(f) Nothing in this section shall be construed to prohibit the practice of school psychology~~
494.24 ~~by a person licensed in accordance with chapters 122A and 129.~~

494.25 Sec. 48. Minnesota Statutes 2016, section 148B.53, subdivision 1, is amended to read:

494.26 Subdivision 1. **General requirements.** (a) To be licensed as a licensed professional
494.27 counselor (LPC), an applicant must provide evidence satisfactory to the board that the
494.28 applicant:

494.29 (1) is at least 18 years of age;

494.30 (2) is of good moral character;

495.1 (3) has completed a master's or doctoral degree program in counseling or a related field,
495.2 as determined by the board based on the criteria in paragraph (b), that includes a minimum
495.3 of 48 semester hours or 72 quarter hours and a supervised field experience of not fewer than
495.4 700 hours that is counseling in nature;

495.5 (4) has submitted to the board a plan for supervision during the first 2,000 hours of
495.6 professional practice or has submitted proof of supervised professional practice that is
495.7 acceptable to the board; and

495.8 (5) has demonstrated competence in professional counseling by passing the National
495.9 Counseling Exam (NCE) administered by the National Board for Certified Counselors, Inc.
495.10 (NBCC) or an equivalent national examination as determined by the board, and ethical,
495.11 oral, and situational examinations if prescribed by the board.

495.12 (b) The degree described in paragraph (a), clause (3), must be from a counseling program
495.13 recognized by the Council for Accreditation of Counseling and Related Education Programs
495.14 (CACREP) or from an institution of higher education that is accredited by a regional
495.15 accrediting organization recognized by the Council for Higher Education Accreditation
495.16 (CHEA). Specific academic course content and training must include course work in each
495.17 of the following subject areas:

495.18 (1) the helping relationship, including counseling theory and practice;

495.19 (2) human growth and development;

495.20 (3) lifestyle and career development;

495.21 (4) group dynamics, processes, counseling, and consulting;

495.22 (5) assessment and appraisal;

495.23 (6) social and cultural foundations, including multicultural issues;

495.24 (7) principles of etiology, treatment planning, and prevention of mental and emotional
495.25 disorders and dysfunctional behavior;

495.26 (8) family counseling and therapy;

495.27 (9) research and evaluation; and

495.28 (10) professional counseling orientation and ethics.

495.29 ~~(c) To be licensed as a professional counselor, a psychological practitioner licensed~~
495.30 ~~under section 148.908 need only show evidence of licensure under that section and is not~~
495.31 ~~required to comply with paragraph (a), clauses (1) to (3) and (5), or paragraph (b).~~

496.1 ~~(d)~~ (c) To be licensed as a professional counselor, a Minnesota licensed psychologist
496.2 need only show evidence of licensure from the Minnesota Board of Psychology and is not
496.3 required to comply with paragraph (a) or (b).

496.4 Sec. 49. Minnesota Statutes 2016, section 150A.06, subdivision 3, is amended to read:

496.5 Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists ~~or~~
496.6 dental therapists, dental hygienists, or dental assistants, except that pertaining to the law of
496.7 Minnesota relating to dentistry and the rules of the board, may, at the discretion of the board,
496.8 be waived for an applicant who presents a certificate of having passed all components of
496.9 the National Board Dental Examinations or evidence of having maintained an adequate
496.10 scholastic standing as determined by the board, ~~in dental school as to dentists, or dental~~
496.11 ~~hygiene school as to dental hygienists.~~

496.12 (b) The board shall waive the clinical examination required for licensure for any dentist
496.13 applicant who is a graduate of a dental school accredited by the Commission on Dental
496.14 Accreditation, who has passed all components of the National Board Dental Examinations,
496.15 and who has satisfactorily completed a Minnesota-based postdoctoral general dentistry
496.16 residency program (GPR) or an advanced education in general dentistry (AEGD) program
496.17 after January 1, 2004. The postdoctoral program must be accredited by the Commission on
496.18 Dental Accreditation, be of at least one year's duration, and include an outcome assessment
496.19 evaluation assessing the resident's competence to practice dentistry. The board may require
496.20 the applicant to submit any information deemed necessary by the board to determine whether
496.21 the waiver is applicable.

496.22 Sec. 50. Minnesota Statutes 2016, section 150A.06, subdivision 8, is amended to read:

496.23 Subd. 8. **Licensure by credentials.** (a) Any dental assistant may, upon application and
496.24 payment of a fee established by the board, apply for licensure based on an evaluation of the
496.25 applicant's education, experience, and performance record in lieu of completing a
496.26 board-approved dental assisting program for expanded functions as defined in rule, and
496.27 may be interviewed by the board to determine if the applicant:

496.28 (1) has graduated from an accredited dental assisting program accredited by the
496.29 Commission on Dental Accreditation, ~~or~~ and is currently certified by the Dental Assisting
496.30 National Board;

496.31 (2) is not subject to any pending or final disciplinary action in another state or Canadian
496.32 province, or if not currently certified or registered, previously had a certification or

497.1 registration in another state or Canadian province in good standing that was not subject to
497.2 any final or pending disciplinary action at the time of surrender;

497.3 (3) is of good moral character and abides by professional ethical conduct requirements;

497.4 (4) at board discretion, has passed a board-approved English proficiency test if English
497.5 is not the applicant's primary language; and

497.6 (5) has met all expanded functions curriculum equivalency requirements of a Minnesota
497.7 board-approved dental assisting program.

497.8 (b) The board, at its discretion, may waive specific licensure requirements in paragraph
497.9 (a).

497.10 (c) An applicant who fulfills the conditions of this subdivision and demonstrates the
497.11 minimum knowledge in dental subjects required for licensure under subdivision 2a must
497.12 be licensed to practice the applicant's profession.

497.13 (d) If the applicant does not demonstrate the minimum knowledge in dental subjects
497.14 required for licensure under subdivision 2a, the application must be denied. If licensure is
497.15 denied, the board may notify the applicant of any specific remedy that the applicant could
497.16 take which, when passed, would qualify the applicant for licensure. A denial does not
497.17 prohibit the applicant from applying for licensure under subdivision 2a.

497.18 (e) A candidate whose application has been denied may appeal the decision to the board
497.19 according to subdivision 4a.

497.20 Sec. 51. Minnesota Statutes 2016, section 150A.10, subdivision 4, is amended to read:

497.21 Subd. 4. **Restorative procedures.** (a) Notwithstanding subdivisions 1, 1a, and 2, a
497.22 licensed dental hygienist or licensed dental assistant may perform the following restorative
497.23 procedures:

497.24 (1) place, contour, and adjust amalgam restorations;

497.25 (2) place, contour, and adjust glass ionomer;

497.26 (3) adapt and cement stainless steel crowns; and

497.27 ~~(4) place, contour, and adjust class I and class V supragingival composite restorations~~
497.28 ~~where the margins are entirely within the enamel; and~~

497.29 ~~(5)~~ (4) place, contour, and adjust class I, II₂ and class V supragingival composite
497.30 restorations on primary teeth and permanent dentition.

497.31 (b) The restorative procedures described in paragraph (a) may be performed only if:

498.1 (1) the licensed dental hygienist or licensed dental assistant has completed a
498.2 board-approved course on the specific procedures;

498.3 (2) the board-approved course includes a component that sufficiently prepares the licensed
498.4 dental hygienist or licensed dental assistant to adjust the occlusion on the newly placed
498.5 restoration;

498.6 (3) a licensed dentist or licensed advanced dental therapist has authorized the procedure
498.7 to be performed; and

498.8 (4) a licensed dentist or licensed advanced dental therapist is available in the clinic while
498.9 the procedure is being performed.

498.10 (c) The dental faculty who teaches the educators of the board-approved courses specified
498.11 in paragraph (b) must have prior experience teaching these procedures in an accredited
498.12 dental education program.

498.13 Sec. 52. Minnesota Statutes 2016, section 214.01, subdivision 2, is amended to read:

498.14 Subd. 2. **Health-related licensing board.** "Health-related licensing board" means the
498.15 Board of Examiners of Nursing Home Administrators established pursuant to section
498.16 144A.19, the Office of Unlicensed Complementary and Alternative Health Care Practice
498.17 established pursuant to section 146A.02, the Board of Medical Practice created pursuant to
498.18 section 147.01, the Board of Nursing created pursuant to section 148.181, the Board of
498.19 Chiropractic Examiners established pursuant to section 148.02, the Board of Optometry
498.20 established pursuant to section 148.52, the Board of Occupational Therapy Practice
498.21 established pursuant to section 148.6449, the Board of Physical Therapy established pursuant
498.22 to section 148.67, the Board of Psychology established pursuant to section 148.90, the Board
498.23 of Social Work pursuant to section 148E.025, the Board of Marriage and Family Therapy
498.24 pursuant to section 148B.30, the Board of Behavioral Health and Therapy established by
498.25 section 148B.51, the Board of Dietetics and Nutrition Practice established under section
498.26 148.622, the Board of Dentistry established pursuant to section 150A.02, the Board of
498.27 Pharmacy established pursuant to section 151.02, the Board of Podiatric Medicine established
498.28 pursuant to section 153.02, and the Board of Veterinary Medicine established pursuant to
498.29 section 156.01.

498.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

499.1 Sec. 53. **BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

499.2 The governor shall appoint all members to the Board of Occupational Therapy Practice
499.3 under Minnesota Statutes, section 148.6449, by October 1, 2017. The governor shall designate
499.4 one member of the board to convene the first meeting of the board by November 1, 2017.
499.5 The board shall elect officers at its first meeting.

499.6 **EFFECTIVE DATE.** This section is effective July 1, 2017.

499.7 Sec. 54. **REVISOR'S INSTRUCTION.**

499.8 In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall replace references
499.9 to Minnesota Statutes, section 148.6450, with Minnesota Statutes, section 148.6449.

499.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

499.11 Sec. 55. **REVISOR'S INSTRUCTION.**

499.12 The revisor of statutes shall change the headnote of Minnesota Statutes, section 147.0375,
499.13 to read "LICENSURE OF EMINENT PHYSICIANS."

499.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

499.15 Sec. 56. **REPEALER.**

499.16 (a) Minnesota Statutes 2016, sections 147A.21; 147B.08, subdivisions 1, 2, and 3;
499.17 147C.40, subdivisions 1, 2, 3, and 4; 148.906; 148.907, subdivision 5; 148.908; 148.909,
499.18 subdivision 7; and 148.96, subdivisions 4 and 5, are repealed.

499.19 (b) Minnesota Statutes 2016, sections 148.6402, subdivision 2; and 148.6450, are
499.20 repealed.

499.21 (c) Minnesota Rules, part 5600.2500, is repealed.

499.22 **EFFECTIVE DATE.** Paragraphs (a) and (c) are effective July 1, 2017. Paragraph (b)
499.23 is effective January 1, 2018.

499.24

ARTICLE 12

499.25

OPIATE ABUSE PREVENTION

499.26 Section 1. Minnesota Statutes 2016, section 151.212, subdivision 2, is amended to read:

499.27 Subd. 2. **Controlled substances.** (a) In addition to the requirements of subdivision 1,
499.28 when the use of any drug containing a controlled substance, as defined in chapter 152, or
499.29 any other drug determined by the board, either alone or in conjunction with alcoholic

500.1 beverages, may impair the ability of the user to operate a motor vehicle, the board shall
500.2 require by rule that notice be prominently set forth on the label or container. Rules
500.3 promulgated by the board shall specify exemptions from this requirement when there is
500.4 evidence that the user will not operate a motor vehicle while using the drug.

500.5 (b) In addition to the requirements of subdivision 1, whenever a prescription drug
500.6 containing an opiate is dispensed to a patient for outpatient use, the pharmacy or practitioner
500.7 dispensing the drug must prominently display on the label or container a notice that states
500.8 "Caution: Opioid. Risk of overdose and addiction."

500.9 Sec. 2. Minnesota Statutes 2016, section 152.11, is amended by adding a subdivision to
500.10 read:

500.11 Subd. 4. **Limit on quantity of opiates prescribed for acute dental and ophthalmic**
500.12 **pain.** (a) When used for the treatment of acute dental pain or acute pain associated with
500.13 refractive surgery, prescriptions for opiate or narcotic pain relievers listed in Schedules II
500.14 through IV of section 152.02 shall not exceed a four-day supply. The quantity prescribed
500.15 shall be consistent with the dosage listed in the professional labeling for the drug that has
500.16 been approved by the United States Food and Drug Administration.

500.17 (b) For the purposes of this subdivision, "acute pain" means pain resulting from disease,
500.18 accidental or intentional trauma, surgery, or another cause, that the practitioner reasonably
500.19 expects to last only a short period of time. Acute pain does not include chronic pain or pain
500.20 being treated as part of cancer care, palliative care, or hospice or other end-of-life care.

500.21 (c) Notwithstanding paragraph (a), if in the professional clinical judgment of a practitioner
500.22 more than a four-day supply of a prescription listed in Schedules II through IV of section
500.23 152.02 is required to treat a patient's acute pain, the practitioner may issue a prescription
500.24 for the quantity needed to treat such acute pain.

500.25 Sec. 3. **CHRONIC PAIN REHABILITATION THERAPY DEMONSTRATION**
500.26 **PROJECT.**

500.27 Subdivision 1. **Establishment.** The commissioner of human services shall award a
500.28 two-year grant to a rehabilitation institute located in Minneapolis operated by a nonprofit
500.29 foundation to participate in a bundled payment arrangement for chronic pain rehabilitation
500.30 therapy for adults who are eligible for fee-for-service medical assistance under Minnesota
500.31 Statutes, section 256B.055. The chronic pain rehabilitation therapy demonstration project
500.32 must include: nonnarcotic medication management, including opioid tapering;
500.33 interdisciplinary care coordination; and group and individual therapy in cognitive behavioral

501.1 therapy and physical therapy. The project may include self-management education in
501.2 nutrition, stress, mental health, substance use, or other modalities, if clinically appropriate.
501.3 The commissioner shall award the grant on a sole-source basis and the program design must
501.4 be mutually agreed upon by the commissioner and the grant recipient. Grant funds are
501.5 available until expended.

501.6 Subd. 2. **Performance measures.** The commissioner shall develop performance measures
501.7 to evaluate the demonstration project. These measures may include:

501.8 (1) reduction in medications, including opioids, taken for pain;

501.9 (2) reduction in emergency department and outpatient clinic utilization related to pain;

501.10 (3) improved ability to return to work, job search, or school;

501.11 (4) patient functional status and satisfaction; and

501.12 (5) rate of program completion.

501.13 Subd. 3. **Eligibility.** (a) To be eligible to participate in the demonstration project, an
501.14 individual must:

501.15 (1) be 21 years of age or older;

501.16 (2) be eligible for fee-for-service medical assistance under Minnesota Statutes, section
501.17 256B.055, and not have other health coverage; and

501.18 (3) meet criteria appropriate for chronic pain rehabilitation.

501.19 (b) In determining the criteria under paragraph (a), clause (3), the commissioner shall
501.20 consider, but is not required to include, the following:

501.21 (1) moderate to severe pain lasting longer than four months;

501.22 (2) an impairment in daily functioning, including work or activities of daily living;

501.23 (3) a referral from a physician or other qualified medical professional indicating that all
501.24 reasonable medical and surgical options have been exhausted; and

501.25 (4) willingness of the patient to engage in chronic pain rehabilitation therapies, including
501.26 opioid tapering.

501.27 Subd. 4. **Payment for services.** The bundled payment shall be billed on a per-person,
501.28 per-day payment and only for days the patient receives services from the grant recipient.
501.29 The grant recipient shall not receive a bundled payment for services provided to the patient
501.30 if a nonbundled medical assistance payment for a service that is part of the bundle is received
501.31 for the same day of service.

502.1 Subd. 5. **Report.** The rehabilitation institute, for the duration of the demonstration
 502.2 project, must annually report on cost savings and performance indicators described in
 502.3 subdivision 2 to the commissioner of human services. One year after the completion of the
 502.4 demonstration project, the commissioner of human services shall submit a report to the
 502.5 chairs and ranking minority members of the legislative committees with jurisdiction over
 502.6 health care. The report shall include an evaluation of the demonstration project, based on
 502.7 the performance measures developed under subdivision 2, and may also include
 502.8 recommendations to increase individual access to chronic pain rehabilitation therapy through
 502.9 Minnesota health care programs.

502.10 **Sec. 4. SUBSTANCE USE DISORDER PROVIDER CAPACITY GRANT**
 502.11 **PROGRAM.**

502.12 The commissioner of human services shall design and implement a grant program to
 502.13 assist providers to purchase the first dose of a nonnarcotic injectable or implantable
 502.14 medication to treat substance use disorder for medical assistance enrollees. Grants shall be
 502.15 distributed between July 1, 2017, and June 30, 2019. The commissioner shall conduct
 502.16 outreach to providers regarding the availability of this grant and ensure a simplified grant
 502.17 application process. The commissioner shall provide technical assistance to assist providers
 502.18 in building operational capacity to treat substance use disorders with nonnarcotic injectable
 502.19 or implantable medications. The commissioner, in collaboration with stakeholders, shall
 502.20 analyze the impact of the grant program under this section and the actual or perceived
 502.21 barriers for providers to access and be reimbursed for nonnarcotic injectable or implantable
 502.22 substance use disorder medications and develop recommendations for addressing identified
 502.23 barriers. The commissioner shall provide a report to the chairs and ranking minority members
 502.24 of the legislative committees with jurisdiction over health and human services policy and
 502.25 finance by September 1, 2019.

502.26 **ARTICLE 13**

502.27 **MISCELLANEOUS**

502.28 Section 1. Minnesota Statutes 2016, section 62K.15, is amended to read:

502.29 **62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT**
 502.30 **PERIODS.**

502.31 (a) Health carriers offering individual health plans must limit annual enrollment in the
 502.32 individual market to the annual open enrollment periods for MNsure. Nothing in this section

503.1 limits the application of special or limited open enrollment periods as defined under the
503.2 Affordable Care Act.

503.3 (b) Health carriers offering individual health plans must inform all applicants at the time
503.4 of application and enrollees at least annually of the open and special enrollment periods as
503.5 defined under the Affordable Care Act.

503.6 (c) Health carriers offering individual health plans must provide a special enrollment
503.7 period for enrollment in the individual market by employees of a small employer that offers
503.8 a qualified small employer health reimbursement arrangement in accordance with United
503.9 States Code, title 26, section 9831(d). The special enrollment period shall be available only
503.10 to employees newly hired by a small employer offering a qualified small employer health
503.11 reimbursement arrangement, and to employees employed by the small employer at the time
503.12 the small employer initially offers a qualified small employer health reimbursement
503.13 arrangement. For employees newly hired by the small employer, the special enrollment
503.14 period shall last for 30 days after the employee's first day of employment. For employees
503.15 employed by the small employer at the time the small employer initially offers a qualified
503.16 small employer health reimbursement arrangement, the special enrollment period shall last
503.17 for 30 days after the date the arrangement is initially offered to employees.

503.18 ~~(e)~~ (d) The commissioner of commerce shall enforce this section.

503.19 Sec. 2. Minnesota Statutes 2016, section 245A.02, subdivision 5a, is amended to read:

503.20 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means a public body,
503.21 governmental agency, business entity, officer, owner, or managerial official whose
503.22 responsibilities include the direction of the management or policies of a program. For
503.23 purposes of this subdivision, owner means an individual who has direct or indirect ownership
503.24 interest in a corporation, partnership, or other business association issued a license under
503.25 this chapter. For purposes of this subdivision, managerial official means those individuals
503.26 who have the decision-making authority related to the operation of the program, and the
503.27 responsibility for the ongoing management of or direction of the policies, services, or
503.28 employees of the program. A site director who has no ownership interest in the program is
503.29 not considered to be a managerial official for purposes of this definition. Controlling
503.30 individual does not include an owner of a program or service provider licensed under this
503.31 chapter and the following individuals, if applicable:

503.32 (1) each officer of the organization, including the chief executive officer and chief
503.33 financial officer;

504.1 (2) the individual designated as the authorized agent under section 245A.04, subdivision
504.2 1, paragraph (b);

504.3 (3) the individual designated as the compliance officer under section 256B.04, subdivision
504.4 21, paragraph (b); and

504.5 (4) each managerial official whose responsibilities include the direction of the
504.6 management or policies of a program.

504.7 (b) Controlling individual does not include:

504.8 (1) a bank, savings bank, trust company, savings association, credit union, industrial
504.9 loan and thrift company, investment banking firm, or insurance company unless the entity
504.10 operates a program directly or through a subsidiary;

504.11 (2) an individual who is a state or federal official, or state or federal employee, or a
504.12 member or employee of the governing body of a political subdivision of the state or federal
504.13 government that operates one or more programs, unless the individual is also an officer,
504.14 owner, or managerial official of the program, receives remuneration from the program, or
504.15 owns any of the beneficial interests not excluded in this subdivision;

504.16 (3) an individual who owns less than five percent of the outstanding common shares of
504.17 a corporation:

504.18 (i) whose securities are exempt under section 80A.45, clause (6); or

504.19 (ii) whose transactions are exempt under section 80A.46, clause (2); ~~or~~

504.20 (4) an individual who is a member of an organization exempt from taxation under section
504.21 290.05, unless the individual is also an officer, owner, or managerial official of the program
504.22 or owns any of the beneficial interests not excluded in this subdivision. This clause does
504.23 not exclude from the definition of controlling individual an organization that is exempt from
504.24 taxation; or

504.25 (5) an employee stock ownership plan trust, or a participant or board member of an
504.26 employee stock ownership plan, unless the participant or board member is a controlling
504.27 individual according to paragraph (a).

504.28 (c) For purposes of this subdivision, "managerial official" means an individual who has
504.29 the decision-making authority related to the operation of the program, and the responsibility
504.30 for the ongoing management of or direction of the policies, services, or employees of the
504.31 program. A site director who has no ownership interest in the program is not considered to
504.32 be a managerial official for purposes of this definition.

505.1 Sec. 3. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to
505.2 read:

505.3 Subd. 10b. **Owner.** "Owner" means an individual or organization that has a direct or
505.4 indirect ownership interest of five percent or more in a program licensed under this chapter.
505.5 For purposes of this subdivision, "direct ownership interest" means the possession of equity
505.6 in capital, stock, or profits of an organization, and "indirect ownership interest" means a
505.7 direct ownership interest in an entity that has a direct or indirect ownership interest in a
505.8 licensed program. For purposes of this chapter, "owner of a nonprofit corporation" means
505.9 the president and treasurer of the board of directors or, for an entity owned by an employee
505.10 stock ownership plan, means the president and treasurer of the entity. A government entity
505.11 that is issued a license under this chapter shall be designated the owner.

505.12

ARTICLE 14

505.13

NURSING FACILITY TECHNICAL CORRECTIONS

505.14 Section 1. Minnesota Statutes 2016, section 144.0722, subdivision 1, as amended by Laws
505.15 2017, chapter 40, article 1, section 18, is amended to read:

505.16 Subdivision 1. **Resident reimbursement classifications.** The commissioner of health
505.17 shall establish resident reimbursement classifications based upon the assessments of residents
505.18 of nursing homes and boarding care homes conducted under section 144.0721, or under
505.19 rules established by the commissioner of human services under ~~sections 256B.421 to 256B.48~~
505.20 chapter 256R. The reimbursement classifications established by the commissioner must
505.21 conform to the rules established by the commissioner of human services.

505.22 Sec. 2. Minnesota Statutes 2016, section 144A.071, subdivision 3, as amended by Laws
505.23 2017, chapter 40, article 1, section 22, is amended to read:

505.24 Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The
505.25 commissioner of health, in coordination with the commissioner of human services, may
505.26 approve the addition of new licensed and Medicare and Medicaid certified nursing home
505.27 beds, using the criteria and process set forth in this subdivision.

505.28 (b) The commissioner, in cooperation with the commissioner of human services, shall
505.29 consider the following criteria when determining that an area of the state is a hardship area
505.30 with regard to access to nursing facility services:

505.31 (1) a low number of beds per thousand in a specified area using as a standard the beds
505.32 per thousand people age 65 and older, in five year age groups, using data from the most

506.1 recent census and population projections, weighted by each group's most recent nursing
506.2 home utilization, of the county at the 20th percentile, as determined by the commissioner
506.3 of human services;

506.4 (2) a high level of out-migration for nursing facility services associated with a described
506.5 area from the county or counties of residence to other Minnesota counties, as determined
506.6 by the commissioner of human services, using as a standard an amount greater than the
506.7 out-migration of the county ranked at the 50th percentile;

506.8 (3) an adequate level of availability of noninstitutional long-term care services measured
506.9 as public spending for home and community-based long-term care services per individual
506.10 age 65 and older, in five year age groups, using data from the most recent census and
506.11 population projections, weighted by each group's most recent nursing home utilization, as
506.12 determined by the commissioner of human services using as a standard an amount greater
506.13 than the 50th percentile of counties;

506.14 (4) there must be a declaration of hardship resulting from insufficient access to nursing
506.15 home beds by local county agencies and area agencies on aging; and

506.16 (5) other factors that may demonstrate the need to add new nursing facility beds.

506.17 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with the
506.18 commissioner of human services, may publish in the State Register a request for information
506.19 in which interested parties, using the data provided under section 144A.351, along with any
506.20 other relevant data, demonstrate that a specified area is a hardship area with regard to access
506.21 to nursing facility services. For a response to be considered, the commissioner must receive
506.22 it by November 15. The commissioner shall make responses to the request for information
506.23 available to the public and shall allow 30 days for comment. The commissioner shall review
506.24 responses and comments and determine if any areas of the state are to be declared hardship
506.25 areas.

506.26 (d) For each designated hardship area determined in paragraph (c), the commissioner
506.27 shall publish a request for proposals in accordance with section 144A.073 and Minnesota
506.28 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
506.29 State Register by March 15 following receipt of responses to the request for information.
506.30 The request for proposals must specify the number of new beds which may be added in the
506.31 designated hardship area, which must not exceed the number which, if added to the existing
506.32 number of beds in the area, including beds in layaway status, would have prevented it from
506.33 being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1,
506.34 2011, the number of new beds approved must not exceed 200 beds statewide per biennium.

507.1 After June 30, 2019, the number of new beds that may be approved in a biennium must not
507.2 exceed 300 statewide. For a proposal to be considered, the commissioner must receive it
507.3 within six months of the publication of the request for proposals. The commissioner shall
507.4 review responses to the request for proposals and shall approve or disapprove each proposal
507.5 by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts
507.6 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a
507.7 comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of
507.8 a proposal expires after 18 months unless the facility has added the new beds using existing
507.9 space, subject to approval by the commissioner, or has commenced construction as defined
507.10 in section 144A.071, subdivision 1a, paragraph (d). If, after the approved beds have been
507.11 added, fewer than 50 percent of the beds in a facility are newly licensed, the operating
507.12 payment rates previously in effect shall remain. If, after the approved beds have been added,
507.13 50 percent or more of the beds in a facility are newly licensed, operating payment rates shall
507.14 be determined according to Minnesota Rules, part 9549.0057, using the limits under ~~chapter~~
507.15 ~~256R~~ sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs
507.16 payment rates must be determined according to ~~chapter 256R~~ section 256R.25. Property
507.17 payment rates for facilities with beds added under this subdivision must be determined in
507.18 the same manner as rate determinations resulting from projects approved and completed
507.19 under section 144A.073.

507.20 (e) The commissioner may:

507.21 (1) certify or license new beds in a new facility that is to be operated by the commissioner
507.22 of veterans affairs or when the costs of constructing and operating the new beds are to be
507.23 reimbursed by the commissioner of veterans affairs or the United States Veterans
507.24 Administration; and

507.25 (2) license or certify beds in a facility that has been involuntarily delicensed or decertified
507.26 for participation in the medical assistance program, provided that an application for
507.27 relicensure or recertification is submitted to the commissioner by an organization that is
507.28 not a related organization as defined in section 256R.02, subdivision 43, to the prior licensee
507.29 within 120 days after delicensure or decertification.

507.30 Sec. 3. Minnesota Statutes 2016, section 144A.071, subdivision 4a, as amended by Laws
507.31 2017, chapter 40, article 1, section 23, is amended to read:

507.32 Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to
507.33 ensure that nursing homes and boarding care homes continue to meet the physical plant
507.34 licensing and certification requirements by permitting certain construction projects. Facilities

508.1 should be maintained in condition to satisfy the physical and emotional needs of residents
508.2 while allowing the state to maintain control over nursing home expenditure growth.

508.3 The commissioner of health in coordination with the commissioner of human services,
508.4 may approve the renovation, replacement, upgrading, or relocation of a nursing home or
508.5 boarding care home, under the following conditions:

508.6 (a) to license or certify beds in a new facility constructed to replace a facility or to make
508.7 repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire,
508.8 lightning, or other hazard provided:

508.9 (i) destruction was not caused by the intentional act of or at the direction of a controlling
508.10 person of the facility;

508.11 (ii) at the time the facility was destroyed or damaged the controlling persons of the
508.12 facility maintained insurance coverage for the type of hazard that occurred in an amount
508.13 that a reasonable person would conclude was adequate;

508.14 (iii) the net proceeds from an insurance settlement for the damages caused by the hazard
508.15 are applied to the cost of the new facility or repairs;

508.16 (iv) the number of licensed and certified beds in the new facility does not exceed the
508.17 number of licensed and certified beds in the destroyed facility; and

508.18 (v) the commissioner determines that the replacement beds are needed to prevent an
508.19 inadequate supply of beds.

508.20 Project construction costs incurred for repairs authorized under this clause shall not be
508.21 considered in the dollar threshold amount defined in subdivision 2;

508.22 (b) to license or certify beds that are moved from one location to another within a nursing
508.23 home facility, provided the total costs of remodeling performed in conjunction with the
508.24 relocation of beds does not exceed \$1,000,000;

508.25 (c) to license or certify beds in a project recommended for approval under section
508.26 144A.073;

508.27 (d) to license or certify beds that are moved from an existing state nursing home to a
508.28 different state facility, provided there is no net increase in the number of state nursing home
508.29 beds;

508.30 (e) to certify and license as nursing home beds boarding care beds in a certified boarding
508.31 care facility if the beds meet the standards for nursing home licensure, or in a facility that
508.32 was granted an exception to the moratorium under section 144A.073, and if the cost of any

509.1 remodeling of the facility does not exceed \$1,000,000. If boarding care beds are licensed
509.2 as nursing home beds, the number of boarding care beds in the facility must not increase
509.3 beyond the number remaining at the time of the upgrade in licensure. The provisions
509.4 contained in section 144A.073 regarding the upgrading of the facilities do not apply to
509.5 facilities that satisfy these requirements;

509.6 (f) to license and certify up to 40 beds transferred from an existing facility owned and
509.7 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
509.8 same location as the existing facility that will serve persons with Alzheimer's disease and
509.9 other related disorders. The transfer of beds may occur gradually or in stages, provided the
509.10 total number of beds transferred does not exceed 40. At the time of licensure and certification
509.11 of a bed or beds in the new unit, the commissioner of health shall delicense and decertify
509.12 the same number of beds in the existing facility. As a condition of receiving a license or
509.13 certification under this clause, the facility must make a written commitment to the
509.14 commissioner of human services that it will not seek to receive an increase in its
509.15 property-related payment rate as a result of the transfers allowed under this paragraph;

509.16 (g) to license and certify nursing home beds to replace currently licensed and certified
509.17 boarding care beds which may be located either in a remodeled or renovated boarding care
509.18 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
509.19 nursing home facility within the identifiable complex of health care facilities in which the
509.20 currently licensed boarding care beds are presently located, provided that the number of
509.21 boarding care beds in the facility or complex are decreased by the number to be licensed as
509.22 nursing home beds and further provided that, if the total costs of new construction,
509.23 replacement, remodeling, or renovation exceed ten percent of the appraised value of the
509.24 facility or \$200,000, whichever is less, the facility makes a written commitment to the
509.25 commissioner of human services that it will not seek to receive an increase in its
509.26 property-related payment rate by reason of the new construction, replacement, remodeling,
509.27 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
509.28 facilities do not apply to facilities that satisfy these requirements;

509.29 (h) to license as a nursing home and certify as a nursing facility a facility that is licensed
509.30 as a boarding care facility but not certified under the medical assistance program, but only
509.31 if the commissioner of human services certifies to the commissioner of health that licensing
509.32 the facility as a nursing home and certifying the facility as a nursing facility will result in
509.33 a net annual savings to the state general fund of \$200,000 or more;

509.34 (i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home
509.35 beds in a facility that was licensed and in operation prior to January 1, 1992;

510.1 (j) to license and certify new nursing home beds to replace beds in a facility acquired
510.2 by the Minneapolis Community Development Agency as part of redevelopment activities
510.3 in a city of the first class, provided the new facility is located within three miles of the site
510.4 of the old facility. Operating and property costs for the new facility must be determined and
510.5 allowed under section 256B.431 or 256B.434 or chapter 256R;

510.6 (k) to license and certify up to 20 new nursing home beds in a community-operated
510.7 hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991,
510.8 that suspended operation of the hospital in April 1986. The commissioner of human services
510.9 shall provide the facility with the same per diem property-related payment rate for each
510.10 additional licensed and certified bed as it will receive for its existing 40 beds;

510.11 (l) to license or certify beds in renovation, replacement, or upgrading projects as defined
510.12 in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's
510.13 remodeling projects do not exceed \$1,000,000;

510.14 (m) to license and certify beds that are moved from one location to another for the
510.15 purposes of converting up to five four-bed wards to single or double occupancy rooms in
510.16 a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity
510.17 of 115 beds;

510.18 (n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing
510.19 facility located in Minneapolis to layaway all of its licensed and certified nursing home
510.20 beds. These beds may be relicensed and recertified in a newly constructed teaching nursing
510.21 home facility affiliated with a teaching hospital upon approval by the legislature. The
510.22 proposal must be developed in consultation with the interagency committee on long-term
510.23 care planning. The beds on layaway status shall have the same status as voluntarily delicensed
510.24 and decertified beds, except that beds on layaway status remain subject to the surcharge in
510.25 section 256.9657. This layaway provision expires July 1, 1998;

510.26 (o) to allow a project which will be completed in conjunction with an approved
510.27 moratorium exception project for a nursing home in southern Cass County and which is
510.28 directly related to that portion of the facility that must be repaired, renovated, or replaced,
510.29 to correct an emergency plumbing problem for which a state correction order has been
510.30 issued and which must be corrected by August 31, 1993;

510.31 (p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing
510.32 facility located in Minneapolis to layaway, upon 30 days prior written notice to the
510.33 commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed
510.34 wards to single or double occupancy. Beds on layaway status shall have the same status as

511.1 voluntarily delicensed and decertified beds except that beds on layaway status remain subject
511.2 to the surcharge in section 256.9657, remain subject to the license application and renewal
511.3 fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In
511.4 addition, at any time within three years of the effective date of the layaway, the beds on
511.5 layaway status may be:

511.6 (1) relicensed and recertified upon relocation and reactivation of some or all of the beds
511.7 to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or
511.8 International Falls; provided that the total project construction costs related to the relocation
511.9 of beds from layaway status for any facility receiving relocated beds may not exceed the
511.10 dollar threshold provided in subdivision 2 unless the construction project has been approved
511.11 through the moratorium exception process under section 144A.073;

511.12 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
511.13 facility which placed the beds in layaway status, if the commissioner has determined a need
511.14 for the reactivation of the beds on layaway status.

511.15 The property-related payment rate of a facility placing beds on layaway status must be
511.16 adjusted by the incremental change in its rental per diem after recalculating the rental per
511.17 diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
511.18 payment rate for a facility relicensing and recertifying beds from layaway status must be
511.19 adjusted by the incremental change in its rental per diem after recalculating its rental per
511.20 diem using the number of beds after the relicensing to establish the facility's capacity day
511.21 divisor, which shall be effective the first day of the month following the month in which
511.22 the relicensing and recertification became effective. Any beds remaining on layaway status
511.23 more than three years after the date the layaway status became effective must be removed
511.24 from layaway status and immediately delicensed and decertified;

511.25 (q) to license and certify beds in a renovation and remodeling project to convert 12
511.26 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
511.27 home that, as of January 1, 1994, met the following conditions: the nursing home was located
511.28 in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the
511.29 top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total
511.30 project construction cost estimate for this project must not exceed the cost estimate submitted
511.31 in connection with the 1993 moratorium exception process;

511.32 (r) to license and certify up to 117 beds that are relocated from a licensed and certified
511.33 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds
511.34 located in South St. Paul, provided that the nursing facility and hospital are owned by the

512.1 same or a related organization and that prior to the date the relocation is completed the
512.2 hospital ceases operation of its inpatient hospital services at that hospital. After relocation,
512.3 the nursing facility's status shall be the same as it was prior to relocation. The nursing
512.4 facility's property-related payment rate resulting from the project authorized in this paragraph
512.5 shall become effective no earlier than April 1, 1996. For purposes of calculating the
512.6 incremental change in the facility's rental per diem resulting from this project, the allowable
512.7 appraised value of the nursing facility portion of the existing health care facility physical
512.8 plant prior to the renovation and relocation may not exceed \$2,490,000;

512.9 (s) to license and certify two beds in a facility to replace beds that were voluntarily
512.10 delicensed and decertified on June 28, 1991;

512.11 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing
512.12 home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure
512.13 and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home
512.14 facility after completion of a construction project approved in 1993 under section 144A.073,
512.15 to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway
512.16 status shall have the same status as voluntarily delicensed or decertified beds except that
512.17 they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway
512.18 status may be relicensed as nursing home beds and recertified at any time within five years
512.19 of the effective date of the layaway upon relocation of some or all of the beds to a licensed
512.20 and certified facility located in Watertown, provided that the total project construction costs
512.21 related to the relocation of beds from layaway status for the Watertown facility may not
512.22 exceed the dollar threshold provided in subdivision 2 unless the construction project has
512.23 been approved through the moratorium exception process under section 144A.073.

512.24 The property-related payment rate of the facility placing beds on layaway status must
512.25 be adjusted by the incremental change in its rental per diem after recalculating the rental
512.26 per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
512.27 payment rate for the facility relicensing and recertifying beds from layaway status must be
512.28 adjusted by the incremental change in its rental per diem after recalculating its rental per
512.29 diem using the number of beds after the relicensing to establish the facility's capacity day
512.30 divisor, which shall be effective the first day of the month following the month in which
512.31 the relicensing and recertification became effective. Any beds remaining on layaway status
512.32 more than five years after the date the layaway status became effective must be removed
512.33 from layaway status and immediately delicensed and decertified;

512.34 (u) to license and certify beds that are moved within an existing area of a facility or to
512.35 a newly constructed addition which is built for the purpose of eliminating three- and four-bed

513.1 rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas
513.2 in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed
513.3 capacity of 129 beds;

513.4 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to
513.5 a 160-bed facility in Crow Wing County, provided all the affected beds are under common
513.6 ownership;

513.7 (w) to license and certify a total replacement project of up to 49 beds located in Norman
513.8 County that are relocated from a nursing home destroyed by flood and whose residents were
513.9 relocated to other nursing homes. The operating cost payment rates for the new nursing
513.10 facility shall be determined based on the interim and settle-up payment provisions of
513.11 Minnesota Rules, part 9549.0057, and the reimbursement provisions of ~~section 256B.431~~
513.12 chapter 256R. Property-related reimbursement rates shall be determined under section
513.13 ~~256B.431~~ 256R.26, taking into account any federal or state flood-related loans or grants
513.14 provided to the facility;

513.15 (x) to license and certify to the licensee of a nursing home in Polk County that was
513.16 destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least
513.17 25 beds to be located in Polk County and up to 104 beds distributed among up to three other
513.18 counties. These beds may only be distributed to counties with fewer than the median number
513.19 of age intensity adjusted beds per thousand, as most recently published by the commissioner
513.20 of human services. If the licensee chooses to distribute beds outside of Polk County under
513.21 this paragraph, prior to distributing the beds, the commissioner of health must approve the
513.22 location in which the licensee plans to distribute the beds. The commissioner of health shall
513.23 consult with the commissioner of human services prior to approving the location of the
513.24 proposed beds. The licensee may combine these beds with beds relocated from other nursing
513.25 facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for
513.26 the new nursing facilities shall be determined based on the interim and settle-up payment
513.27 provisions of ~~section 256B.431 or 256B.434, chapter 256R, or~~ Minnesota Rules, parts
513.28 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under
513.29 ~~section 256B.431 or 256B.434 or chapter 256R~~ 256R.26. If the replacement beds permitted
513.30 under this paragraph are combined with beds from other nursing facilities, the rates shall
513.31 be calculated as the weighted average of rates determined as provided in this paragraph and
513.32 ~~chapter 256R~~ section 256R.50;

513.33 (y) to license and certify beds in a renovation and remodeling project to convert 13
513.34 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add
513.35 improvements in a nursing home that, as of January 1, 1994, met the following conditions:

514.1 the nursing home was located in Ramsey County, was not owned by a hospital corporation,
514.2 had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by
514.3 the 1993 moratorium exceptions advisory review panel. The total project construction cost
514.4 estimate for this project must not exceed the cost estimate submitted in connection with the
514.5 1993 moratorium exception process;

514.6 (z) to license and certify up to 150 nursing home beds to replace an existing 285 bed
514.7 nursing facility located in St. Paul. The replacement project shall include both the renovation
514.8 of existing buildings and the construction of new facilities at the existing site. The reduction
514.9 in the licensed capacity of the existing facility shall occur during the construction project
514.10 as beds are taken out of service due to the construction process. Prior to the start of the
514.11 construction process, the facility shall provide written information to the commissioner of
514.12 health describing the process for bed reduction, plans for the relocation of residents, and
514.13 the estimated construction schedule. The relocation of residents shall be in accordance with
514.14 the provisions of law and rule;

514.15 (aa) to allow the commissioner of human services to license an additional 36 beds to
514.16 provide residential services for the physically disabled under Minnesota Rules, parts
514.17 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
514.18 the total number of licensed and certified beds at the facility does not increase;

514.19 (bb) to license and certify a new facility in St. Louis County with 44 beds constructed
514.20 to replace an existing facility in St. Louis County with 31 beds, which has resident rooms
514.21 on two separate floors and an antiquated elevator that creates safety concerns for residents
514.22 and prevents nonambulatory residents from residing on the second floor. The project shall
514.23 include the elimination of three- and four-bed rooms;

514.24 (cc) to license and certify four beds in a 16-bed certified boarding care home in
514.25 Minneapolis to replace beds that were voluntarily delicensed and decertified on or before
514.26 March 31, 1992. The licensure and certification is conditional upon the facility periodically
514.27 assessing and adjusting its resident mix and other factors which may contribute to a potential
514.28 institution for mental disease declaration. The commissioner of human services shall retain
514.29 the authority to audit the facility at any time and shall require the facility to comply with
514.30 any requirements necessary to prevent an institution for mental disease declaration, including
514.31 delicensure and decertification of beds, if necessary;

514.32 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80
514.33 beds as part of a renovation project. The renovation must include construction of an addition
514.34 to accommodate ten residents with beginning and midstage dementia in a self-contained

515.1 living unit; creation of three resident households where dining, activities, and support spaces
515.2 are located near resident living quarters; designation of four beds for rehabilitation in a
515.3 self-contained area; designation of 30 private rooms; and other improvements;

515.4 (ee) to license and certify beds in a facility that has undergone replacement or remodeling
515.5 as part of a planned closure under section 256R.40;

515.6 (ff) to license and certify a total replacement project of up to 124 beds located in Wilkin
515.7 County that are in need of relocation from a nursing home significantly damaged by flood.
515.8 The operating cost payment rates for the new nursing facility shall be determined based on
515.9 the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the
515.10 reimbursement provisions of ~~section 256B.431~~ chapter 256R. Property-related reimbursement
515.11 rates shall be determined under section ~~256B.431~~ 256R.26, taking into account any federal
515.12 or state flood-related loans or grants provided to the facility;

515.13 (gg) to allow the commissioner of human services to license an additional nine beds to
515.14 provide residential services for the physically disabled under Minnesota Rules, parts
515.15 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the
515.16 total number of licensed and certified beds at the facility does not increase;

515.17 (hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility
515.18 in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new
515.19 facility is located within four miles of the existing facility and is in Anoka County. Operating
515.20 and property rates shall be determined and allowed under ~~section 256B.431~~ chapter 256R
515.21 and Minnesota Rules, parts 9549.0010 to 9549.0080, ~~or section 256B.434 or chapter 256R~~;
515.22 or

515.23 (ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that,
515.24 as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit
515.25 nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective
515.26 when the receiving facility notifies the commissioner in writing of the number of beds
515.27 accepted. The commissioner shall place all transferred beds on layaway status held in the
515.28 name of the receiving facility. The layaway adjustment provisions of section 256B.431,
515.29 subdivision 30, do not apply to this layaway. The receiving facility may only remove the
515.30 beds from layaway for recertification and relicensure at the receiving facility's current site,
515.31 or at a newly constructed facility located in Anoka County. The receiving facility must
515.32 receive statutory authorization before removing these beds from layaway status, or may
515.33 remove these beds from layaway status if removal from layaway status is part of a
515.34 moratorium exception project approved by the commissioner under section 144A.073.

516.1 Sec. 4. Minnesota Statutes 2016, section 144A.071, subdivision 4c, as amended by Laws
516.2 2017, chapter 40, article 1, section 24, is amended to read:

516.3 Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner
516.4 of health, in coordination with the commissioner of human services, may approve the
516.5 renovation, replacement, upgrading, or relocation of a nursing home or boarding care home,
516.6 under the following conditions:

516.7 (1) to license and certify an 80-bed city-owned facility in Nicollet County to be
516.8 constructed on the site of a new city-owned hospital to replace an existing 85-bed facility
516.9 attached to a hospital that is also being replaced. The threshold allowed for this project
516.10 under section 144A.073 shall be the maximum amount available to pay the additional
516.11 medical assistance costs of the new facility;

516.12 (2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis
516.13 County, provided that the 29 beds must be transferred from active or layaway status at an
516.14 existing facility in St. Louis County that had 235 beds on April 1, 2003.

516.15 The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment
516.16 rate at that facility shall not be adjusted as a result of this transfer. The operating payment
516.17 rate of the facility adding beds after completion of this project shall be the same as it was
516.18 on the day prior to the day the beds are licensed and certified. This project shall not proceed
516.19 unless it is approved and financed under the provisions of section 144A.073;

516.20 (3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new
516.21 beds are transferred from a 45-bed facility in Austin under common ownership that is closed
516.22 and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common
516.23 ownership; (ii) the commissioner of human services is authorized by the 2004 legislature
516.24 to negotiate budget-neutral planned nursing facility closures; and (iii) money is available
516.25 from planned closures of facilities under common ownership to make implementation of
516.26 this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be
516.27 reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall
516.28 be used for a special care unit for persons with Alzheimer's disease or related dementias;

516.29 (4) to license and certify up to 80 beds transferred from an existing state-owned nursing
516.30 facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching
516.31 campus. The operating cost payment rates for the new facility shall be determined based
516.32 on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and
516.33 the reimbursement provisions of ~~section 256B.431~~ chapter 256R. The property payment
516.34 rate for the first three years of operation shall be \$35 per day. For subsequent years, the

517.1 property payment rate of \$35 per day shall be adjusted for inflation as provided in section
517.2 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section
517.3 256B.434;

517.4 (5) to initiate a pilot program to license and certify up to 80 beds transferred from an
517.5 existing county-owned nursing facility in Steele County relocated to the site of a new acute
517.6 care facility as part of the county's Communities for a Lifetime comprehensive plan to create
517.7 innovative responses to the aging of its population. Upon relocation to the new site, the
517.8 nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the
517.9 new facility shall be increased by an amount as calculated according to items (i) to (v):

517.10 (i) compute the estimated decrease in medical assistance residents served by the nursing
517.11 facility by multiplying the decrease in licensed beds by the historical percentage of medical
517.12 assistance resident days;

517.13 (ii) compute the annual savings to the medical assistance program from the delicensure
517.14 of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined
517.15 in item (i), by the existing facility's weighted average payment rate multiplied by 365;

517.16 (iii) compute the anticipated annual costs for community-based services by multiplying
517.17 the anticipated decrease in medical assistance residents served by the nursing facility,
517.18 determined in item (i), by the average monthly elderly waiver service costs for individuals
517.19 in Steele County multiplied by 12;

517.20 (iv) subtract the amount in item (iii) from the amount in item (ii);

517.21 (v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's
517.22 occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the
517.23 historical percentage of medical assistance resident days; and

517.24 (6) to consolidate and relocate nursing facility beds to a new site in Goodhue County
517.25 and to integrate these services with other community-based programs and services under a
517.26 communities for a lifetime pilot program and comprehensive plan to create innovative
517.27 responses to the aging of its population. Two nursing facilities, one for 84 beds and one for
517.28 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly
517.29 renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding
517.30 the carryforward of the approval authority in section 144A.073, subdivision 11, the funding
517.31 approved in April 2009 by the commissioner of health for a project in Goodhue County
517.32 shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure
517.33 rate adjustment under section 256R.40. The construction project permitted in this clause
517.34 shall not be eligible for a threshold project rate adjustment under section 256B.434,

518.1 subdivision 4f. The payment rate for external fixed costs for the new facility shall be
518.2 increased by an amount as calculated according to items (i) to (vi):

518.3 (i) compute the estimated decrease in medical assistance residents served by both nursing
518.4 facilities by multiplying the difference between the occupied beds of the two nursing facilities
518.5 for the reporting year ending September 30, 2009, and the projected occupancy of the facility
518.6 at 95 percent occupancy by the historical percentage of medical assistance resident days;

518.7 (ii) compute the annual savings to the medical assistance program from the delicensure
518.8 by multiplying the anticipated decrease in the medical assistance residents, determined in
518.9 item (i), by the hospital-owned nursing facility weighted average payment rate multiplied
518.10 by 365;

518.11 (iii) compute the anticipated annual costs for community-based services by multiplying
518.12 the anticipated decrease in medical assistance residents served by the facilities, determined
518.13 in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue
518.14 County multiplied by 12;

518.15 (iv) subtract the amount in item (iii) from the amount in item (ii);

518.16 (v) multiply the amount in item (iv) by 57.2 percent; and

518.17 (vi) divide the difference of the amount in item (iv) and the amount in item (v) by an
518.18 amount equal to the relocated nursing facility's occupancy factor under section 256B.431,
518.19 subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance
518.20 resident days.

518.21 (b) Projects approved under this subdivision shall be treated in a manner equivalent to
518.22 projects approved under subdivision 4a.

518.23 Sec. 5. Minnesota Statutes 2016, section 144A.10, subdivision 4, as amended by Laws
518.24 2017, chapter 40, article 1, section 27, is amended to read:

518.25 Subd. 4. **Correction orders.** Whenever a duly authorized representative of the
518.26 commissioner of health finds upon inspection of a nursing home, that the facility or a
518.27 controlling person or an employee of the facility is not in compliance with sections 144.411
518.28 to 144.417, 144.651, 144.6503, 144A.01 to 144A.155, or 626.557 or the rules promulgated
518.29 thereunder, a correction order shall be issued to the facility. The correction order shall state
518.30 the deficiency, cite the specific rule or statute violated, state the suggested method of
518.31 correction, and specify the time allowed for correction. If the commissioner finds that the
518.32 nursing home had uncorrected or repeated violations which create a risk to resident care,
518.33 safety, or rights, the commissioner shall notify the commissioner of human services who

519.1 ~~shall require the facility to use any incentive payments received under section 256R.38, to~~
519.2 ~~correct the violations and shall require the facility to forfeit incentive payments for failure~~
519.3 ~~to correct the violations. The forfeiture shall not apply to correction orders issued for physical~~
519.4 ~~plant deficiencies.~~

519.5 Sec. 6. Minnesota Statutes 2016, section 144A.74, is amended to read:

519.6 **144A.74 MAXIMUM CHARGES.**

519.7 A supplemental nursing services agency must not bill or receive payments from a nursing
519.8 home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted
519.9 average wage rate, plus a factor determined by the commissioner to incorporate payroll
519.10 taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision
519.11 37, for the applicable employee classification for the geographic group to which the nursing
519.12 home is assigned under Minnesota Rules, part 9549.0052. The weighted average wage rates
519.13 must be determined by the commissioner of human services and reported to the commissioner
519.14 of health on an annual basis. Wages are defined as hourly rate of pay and shift differential,
519.15 including weekend shift differential and overtime. Facilities shall provide information
519.16 necessary to determine weighted average wage rates to the commissioner of human services
519.17 in a format requested by the commissioner. The maximum rate must include all charges for
519.18 administrative fees, contract fees, or other special charges in addition to the hourly rates for
519.19 the temporary nursing pool personnel supplied to a nursing home.

519.20 Sec. 7. Minnesota Statutes 2016, section 256.9657, subdivision 1, is amended to read:

519.21 Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each
519.22 non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner
519.23 an annual surcharge according to the schedule in subdivision 4. The surcharge shall be
519.24 calculated as \$620 per licensed bed. If the number of licensed beds is reduced, the surcharge
519.25 shall be based on the number of remaining licensed beds the second month following the
519.26 receipt of timely notice by the commissioner of human services that beds have been
519.27 delicensed. The nursing home must notify the commissioner of health in writing when beds
519.28 are delicensed. The commissioner of health must notify the commissioner of human services
519.29 within ten working days after receiving written notification. If the notification is received
519.30 by the commissioner of human services by the 15th of the month, the invoice for the second
519.31 following month must be reduced to recognize the delicensing of beds. Beds on layaway
519.32 status continue to be subject to the surcharge. The commissioner of human services must

520.1 acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal
520.2 from the provider.

520.3 (b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to \$625.

520.4 (c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to
520.5 \$990.

520.6 (d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to
520.7 \$2,815.

520.8 (e) The commissioner may reduce, and may subsequently restore, the surcharge under
520.9 paragraph (d) based on the commissioner's determination of a permissible surcharge.

520.10 ~~(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision~~
520.11 ~~may elect to assume full participation in the medical assistance program by agreeing to~~
520.12 ~~comply with all of the requirements of the medical assistance program, including the rate~~
520.13 ~~equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements~~
520.14 ~~established in law or rule, and to begin intake of new medical assistance recipients. Rates~~
520.15 ~~will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Rate calculations~~
520.16 ~~will be subject to limits as prescribed in rule and law. Other than the adjustments in sections~~
520.17 ~~256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota~~
520.18 ~~Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization~~
520.19 ~~of rates, facilities assuming full participation in medical assistance under this paragraph are~~
520.20 ~~not eligible for any rate adjustments until the July 1 following their settle-up period.~~

520.21 Sec. 8. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

520.22 Subd. 3e. **Customized living service rate.** (a) Payment for customized living services
520.23 shall be a monthly rate authorized by the lead agency within the parameters established by
520.24 the commissioner. The payment agreement must delineate the amount of each component
520.25 service included in the recipient's customized living service plan. The lead agency, with
520.26 input from the provider of customized living services, shall ensure that there is a documented
520.27 need within the parameters established by the commissioner for all component customized
520.28 living services authorized.

520.29 (b) The payment rate must be based on the amount of component services to be provided
520.30 utilizing component rates established by the commissioner. Counties and tribes shall use
520.31 tools issued by the commissioner to develop and document customized living service plans
520.32 and rates.

521.1 (c) Component service rates must not exceed payment rates for comparable elderly
521.2 waiver or medical assistance services and must reflect economies of scale. Customized
521.3 living services must not include rent or raw food costs.

521.4 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
521.5 individualized monthly authorized payment for the customized living service plan shall not
521.6 exceed 50 percent of the greater of either the statewide or any of the geographic groups'
521.7 weighted average monthly nursing facility rate of the case mix resident class to which the
521.8 elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051
521.9 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph
521.10 (a). Effective on July 1 of the state fiscal year in which the resident assessment system as
521.11 described in section ~~256B.438~~ 256R.17 for nursing home rate determination is implemented
521.12 and July 1 of each subsequent state fiscal year, the individualized monthly authorized
521.13 payment for the services described in this clause shall not exceed the limit which was in
521.14 effect on June 30 of the previous state fiscal year updated annually based on legislatively
521.15 adopted changes to all service rate maximums for home and community-based service
521.16 providers.

521.17 (e) Effective July 1, 2011, the individualized monthly payment for the customized living
521.18 service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly
521.19 authorized payment limit for customized living for individuals classified as case mix A,
521.20 reduced by 25 percent. This rate limit must be applied to all new participants enrolled in
521.21 the program on or after July 1, 2011, who meet the criteria described in subdivision 3a,
521.22 paragraph (b). This monthly limit also applies to all other participants who meet the criteria
521.23 described in subdivision 3a, paragraph (b), at reassessment.

521.24 (f) Customized living services are delivered by a provider licensed by the Department
521.25 of Health as a class A or class F home care provider and provided in a building that is
521.26 registered as a housing with services establishment under chapter 144D. Licensed home
521.27 care providers are subject to section 256B.0651, subdivision 14.

521.28 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
521.29 family for additional units of any allowable component service beyond those available under
521.30 the service rate limits described in paragraph (d), nor for additional units of any allowable
521.31 component service beyond those approved in the service plan by the lead agency.

521.32 (h) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits
521.33 for customized living services under this subdivision shall be increased by the difference
521.34 between any legislatively adopted home and community-based provider rate increases

522.1 effective on July 1 or since the previous July 1 and the average statewide percentage increase
522.2 in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~
522.3 chapter 256R, effective the previous January 1. This paragraph shall only apply if the average
522.4 statewide percentage increase in nursing facility operating payment rates is greater than any
522.5 legislatively adopted home and community-based provider rate increases effective on July
522.6 1, or occurring since the previous July 1.

522.7 Sec. 9. Minnesota Statutes 2016, section 256B.35, subdivision 4, as amended by Laws
522.8 2017, chapter 40, article 1, section 72, is amended to read:

522.9 Subd. 4. **Field audits required.** The commissioner of human services shall conduct
522.10 field audits at the same time as cost report audits required under section 256R.13, subdivision
522.11 1, and at any other time but at least once every four years, without notice, to determine
522.12 whether this section was complied with and that the funds provided residents for their
522.13 personal needs were actually expended for that purpose.

522.14 Sec. 10. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

522.15 Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July
522.16 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway
522.17 shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph
522.18 (c), and calculation of the rental per diem, have those beds given the same effect as if the
522.19 beds had been delicensed so long as the beds remain on layaway. At the time of a layaway,
522.20 a facility may change its single bed election for use in calculating capacity days under
522.21 Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be
522.22 effective the first day of the month following the month in which the layaway of the beds
522.23 becomes effective under section 144A.071, subdivision 4b.

522.24 (b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to
522.25 the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under
522.26 that section or chapter which has placed beds on layaway shall, for so long as the beds
522.27 remain on layaway, be allowed to:

522.28 (1) aggregate the applicable investment per bed limits based on the number of beds
522.29 licensed immediately prior to entering the alternative payment system;

522.30 (2) retain or change the facility's single bed election for use in calculating capacity days
522.31 under Minnesota Rules, part 9549.0060, subpart 11; and

523.1 (3) establish capacity days based on the number of beds immediately prior to the layaway
523.2 and the number of beds after the layaway.

523.3 The commissioner shall increase the facility's property payment rate by the incremental
523.4 increase in the rental per diem resulting from the recalculation of the facility's rental per
523.5 diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and
523.6 (3). If a facility reimbursed under section 256B.434 or chapter 256R completes a moratorium
523.7 exception project after its base year, the base year property rate shall be the moratorium
523.8 project property rate. The base year rate shall be inflated by the factors in section 256B.434,
523.9 subdivision 4, paragraph (c). The property payment rate increase shall be effective the first
523.10 day of the month following the month in which the layaway of the beds becomes effective.

523.11 (c) If a nursing facility removes a bed from layaway status in accordance with section
523.12 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the
523.13 number of licensed and certified beds in the facility not on layaway and shall reduce the
523.14 nursing facility's property payment rate in accordance with paragraph (b).

523.15 (d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision
523.16 to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under
523.17 that section or chapter, which has delicensed beds after July 1, 2000, by giving notice of
523.18 the delicensure to the commissioner of health according to the notice requirements in section
523.19 144A.071, subdivision 4b, shall be allowed to:

523.20 (1) aggregate the applicable investment per bed limits based on the number of beds
523.21 licensed immediately prior to entering the alternative payment system;

523.22 (2) retain or change the facility's single bed election for use in calculating capacity days
523.23 under Minnesota Rules, part 9549.0060, subpart 11; and

523.24 (3) establish capacity days based on the number of beds immediately prior to the
523.25 delicensure and the number of beds after the delicensure.

523.26 The commissioner shall increase the facility's property payment rate by the incremental
523.27 increase in the rental per diem resulting from the recalculation of the facility's rental per
523.28 diem applying only the changes resulting from the delicensure of beds and clauses (1), (2),
523.29 and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
523.30 project after its base year, the base year property rate shall be the moratorium project property
523.31 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
523.32 paragraph (c). The property payment rate increase shall be effective the first day of the
523.33 month following the month in which the delicensure of the beds becomes effective.

524.1 (e) For nursing facilities reimbursed under this section ~~or~~ section 256B.434, or chapter
 524.2 256R, any beds placed on layaway shall not be included in calculating facility occupancy
 524.3 as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

524.4 (f) For nursing facilities reimbursed under this section ~~or~~ section 256B.434, or chapter
 524.5 256R, the rental rate calculated after placing beds on layaway may not be less than the rental
 524.6 rate prior to placing beds on layaway.

524.7 (g) A nursing facility receiving a rate adjustment as a result of this section shall comply
 524.8 with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

524.9 (h) A facility that does not utilize the space made available as a result of bed layaway
 524.10 or delicensure under this subdivision to reduce the number of beds per room or provide
 524.11 more common space for nursing facility uses or perform other activities related to the
 524.12 operation of the nursing facility shall have its property rate increase calculated under this
 524.13 subdivision reduced by the ratio of the square footage made available that is not used for
 524.14 these purposes to the total square footage made available as a result of bed layaway or
 524.15 delicensure.

524.16 Sec. 11. **EFFECTIVE DATE.**

524.17 Sections 1 to 10 are effective the day following final enactment.

524.18 **ARTICLE 15**

524.19 **MANAGED CARE ORGANIZATIONS**

524.20 Section 1. Minnesota Statutes 2016, section 256.045, subdivision 3a, is amended to read:

524.21 Subd. 3a. **Prepaid health plan appeals.** (a) All prepaid health plans under contract to
 524.22 the commissioner under chapter 256B must provide for a complaint system according to
 524.23 section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service
 524.24 or denies a request to authorize a previously authorized health service, the prepaid health
 524.25 plan must notify the recipient of the right to file a complaint or an appeal. The notice must
 524.26 include the name and telephone number of the ombudsman and notice of the recipient's
 524.27 right to request a hearing under paragraph (b). Recipients may request the assistance of the
 524.28 ombudsman in the complaint system process. The prepaid health plan must issue a written
 524.29 resolution of the complaint to the recipient within 30 days after the complaint is filed with
 524.30 the prepaid health plan. A recipient is ~~not~~ required to exhaust the complaint system
 524.31 procedures in order to request a hearing under paragraph (b).

525.1 (b) Recipients enrolled in a prepaid health plan under chapter 256B may contest a prepaid
 525.2 health plan's denial, reduction, or termination of health services, a prepaid health plan's
 525.3 denial of a request to authorize a previously authorized health service, or the prepaid health
 525.4 plan's written resolution of a complaint by submitting a written request for a hearing
 525.5 according to subdivision 3. A state human services judge shall conduct a hearing on the
 525.6 matter and shall recommend an order to the commissioner of human services. The
 525.7 commissioner need not grant a hearing if the sole issue raised by a recipient is the
 525.8 commissioner's authority to require mandatory enrollment in a prepaid health plan in a
 525.9 county where prepaid health plans are under contract with the commissioner. The state
 525.10 human services judge may order a second medical opinion from ~~the prepaid health plan or~~
 525.11 ~~may order a second medical opinion from~~ a nonprepaid health plan provider at the expense
 525.12 of the ~~prepaid health plan~~ Department of Human Services. Recipients may request the
 525.13 assistance of the ombudsman in the appeal process.

525.14 (c) In the written request for a hearing to appeal from a prepaid health plan's denial,
 525.15 reduction, or termination of a health service, a prepaid health plan's denial of a request to
 525.16 authorize a previously authorized service, or the prepaid health plan's written resolution to
 525.17 a complaint, a recipient may request an expedited hearing. If an expedited appeal is
 525.18 warranted, the state human services judge shall hear the appeal and render a decision within
 525.19 a time commensurate with the level of urgency involved, based on the individual
 525.20 circumstances of the case.

525.21 (d) Beginning January 1, 2018, the requirements of Code of Federal Regulations, part
 525.22 42, sections 438.400 to 438.424, take precedent over any conflicting provisions in this
 525.23 subdivision. All other provisions of this section remain in effect.

525.24 Sec. 2. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision to
 525.25 read:

525.26 Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee
 525.27 support system that provides support to an enrollee before and during enrollment in a
 525.28 managed care plan.

525.29 (b) The enrollee support system must:

525.30 (1) provide access to counseling for each potential enrollee on choosing a managed care
 525.31 plan;

525.32 (2) assist an enrollee in understanding enrollment in a managed care plan;

526.1 (3) provide an access point for complaints regarding enrollment, covered services, and
526.2 other related matters;

526.3 (4) provide information on an enrollee's grievance and appeal rights within the managed
526.4 care organization and the state's fair hearing process, including an enrollee's rights and
526.5 responsibilities; and

526.6 (5) provide assistance to an enrollee, upon request, in navigating the grievance and
526.7 appeals process within the managed care organization and in appealing adverse benefit
526.8 determinations made by the managed care organization to the state's fair hearing process
526.9 after the managed care organization's internal appeals process has been exhausted. Assistance
526.10 does not include providing representation to an enrollee at the state's fair hearing, but may
526.11 include a referral to appropriate legal representation sources.

526.12 (c) Outreach to enrollees through the support system must be accessible to an enrollee
526.13 through multiple formats, including telephone, Internet, in-person, and, if requested, through
526.14 auxiliary aids and services.

526.15 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting
526.16 a managed care organization and providing necessary enrollment information. For purposes
526.17 of this subdivision, "enrollment broker" means an individual or entity that performs choice
526.18 counseling or enrollment activities in accordance with Code of Federal Regulations, part
526.19 42, section 438.810, or both.

526.20 Sec. 3. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision to
526.21 read:

526.22 Subd. 37. **Networks.** (a) The commissioner shall ensure that a managed care
526.23 organization's network providers are enrolled with the commissioner as medical assistance
526.24 providers, and that the providers comply with the provider disclosure, screening, and
526.25 enrollment requirements in Code of Federal Regulations, part 42, section 455. A provider
526.26 that has a network provider contract with the managed care organization is not required to
526.27 provide services to a medical assistance or MinnesotaCare recipient who is receiving services
526.28 through the fee-for-service system.

526.29 (b) A managed care organization may enter into a network provider contract with a
526.30 provider that is not a medical assistance provider for a period of up to 120 days pending the
526.31 outcome of the medical assistance provider enrollment process. A managed care organization
526.32 must terminate the contract upon notification that the provider cannot be enrolled as a
526.33 medical assistance provider or upon expiration of the 120-day period if notification has not

527.1 been received within that period. The managed care organization must notify each affected
 527.2 enrollee of the provider contract termination.

527.3 (c) For purposes of this subdivision, "network provider" means any provider, group of
 527.4 providers, entity with a network provider agreement with the managed care organization,
 527.5 or subcontractor that receives payments from the managed care organization either directly
 527.6 or indirectly to provide services under a managed care contract between the commissioner
 527.7 and the managed care organization.

527.8 **Sec. 4. [256B.6925] ENROLLEE INFORMATION.**

527.9 Subdivision 1. **Information provided by the commissioner.** The commissioner shall
 527.10 provide to each potential enrollee the following information:

527.11 (1) basic features of receiving services through managed care;

527.12 (2) which individuals are excluded from managed care enrollment, subject to mandatory
 527.13 managed care enrollment, or who may choose to enroll voluntarily;

527.14 (3) for mandatory and voluntary enrollment, the length of the enrollment period and
 527.15 information about an enrollee's right to disenroll in accordance with Code of Federal
 527.16 Regulations, part 42, section 438.56;

527.17 (4) the service area covered by each managed care organization;

527.18 (5) covered services, including services provided by the managed care organization and
 527.19 services provided by the commissioner;

527.20 (6) the provider directory and drug formulary for each managed care organization;

527.21 (7) cost-sharing requirements;

527.22 (8) requirements for adequate access to services, including provider network adequacy
 527.23 standards;

527.24 (9) a managed care organization's responsibility for coordination of enrollee care; and

527.25 (10) quality and performance indicators, including enrollee satisfaction for each managed
 527.26 care organization, if available.

527.27 Subd. 2. **Information provided by the managed care organization.** The commissioner
 527.28 shall ensure that managed care organizations provide to each enrollee the following
 527.29 information:

527.30 (1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's
 527.31 enrollment. The handbook must, at a minimum, include information on benefits provided,

528.1 how and where to access benefits, cost-sharing requirements, how transportation is provided,
528.2 and other information as required by Code of Federal Regulations, part 42, section 438.10,
528.3 paragraph (g);

528.4 (2) a provider directory for the following provider types: physicians, specialists, hospitals,
528.5 pharmacies, behavioral health providers, and long-term supports and services providers, as
528.6 appropriate. The directory must include the provider's name, group affiliation, street address,
528.7 telephone number, Web site, specialty if applicable, whether the provider accepts new
528.8 enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal
528.9 Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office
528.10 accommodates people with disabilities;

528.11 (3) a drug formulary that includes both generic and name brand medications that are
528.12 covered and each medication tier, if applicable;

528.13 (4) written notice of termination of a contracted provider. Within 15 calendar days after
528.14 receipt or issuance of the termination notice, the managed care organization must make a
528.15 good faith effort to provide notice to each enrollee who received primary care from, or was
528.16 seen on a regular basis by, the terminated provider; and

528.17 (5) upon enrollee request, the managed care organization's physician incentive plan.

528.18 **Subd. 3. Provision of information.** (a) All information required to be provided to
528.19 enrollees and potential enrollees of a managed care organization, including the provider
528.20 directory, enrollee handbook, and drug formulary, must be provided in a manner and format
528.21 that is easily understood and readily accessible. The information must be available through
528.22 the enrollee support system established under section 256B.69, subdivision 36, the
528.23 department's Web site and each managed care organization's Web site. The commissioner
528.24 and managed care organization shall inform each enrollee that the information is available
528.25 on the department's and the managed care organization's Web sites and shall provide the
528.26 potential enrollee or enrollee with the applicable URL to access the information. An enrollee
528.27 with a disability who cannot access the information online must be provided, upon request,
528.28 with auxiliary aids and services necessary to access the information at no cost to the enrollee.

528.29 (b) The commissioner and managed care organization shall provide all required
528.30 information electronically to potential enrollees and enrollees unless the enrollee requests
528.31 the information in paper form. The commissioner and managed care organization shall
528.32 inform an enrollee that, upon request, the information is available in paper form without
528.33 charge to the enrollee, and shall mail the information to the potential enrollee's or the
528.34 enrollee's mailing address within five business days of the request. If the information is

529.1 provided to the enrollee through e-mail, the managed care organization must receive the
529.2 enrollee's agreement before providing the information by e-mail.

529.3 (c) The information required to be provided electronically to a potential enrollee or
529.4 enrollee must:

529.5 (1) be readily accessible;

529.6 (2) be published in a prominent location on the commissioner's and managed care
529.7 organization's Web sites in a format that has the capability of being retained and printed;
529.8 and

529.9 (3) satisfy the requirements for content and language requirements in accordance with
529.10 Code of Federal Regulations, part 42, section 438.10, paragraph (d).

529.11 Subd. 4. **Language and accessibility standards.** (a) Managed care contracts entered
529.12 into under section 256B.69, 256B.692, or 256L.12, must require a managed care organization
529.13 to provide language assistance, and auxiliary aids and services, if requested, to ensure access
529.14 to a managed care organization's programs and services, as required under United States
529.15 Code, title 42, sections 18116 and 2000d, and any other federal regulations or guidance
529.16 from the United States Department of Health and Human Services.

529.17 (b) The commissioner shall establish a methodology to identify the prevalent non-English
529.18 languages spoken by enrollees and potential enrollees throughout Minnesota and in each
529.19 managed care organization's service area.

529.20 (c) The commissioner shall ensure that oral interpretation is provided in all languages
529.21 and written interpretation is provided in each prevalent non-English language, and that both
529.22 are available to enrollees and potential enrollees free of charge. Oral interpretation services
529.23 shall include the use of auxiliary aids, TTY/TDY, and American sign language.

529.24 (d) All written materials that target potential enrollees and are provided to enrollees,
529.25 including the provider directory, enrollee handbook, appeals and grievance notices, and
529.26 denial and termination notices, must:

529.27 (1) use at least 12-point font;

529.28 (2) be written at a 7th grade reading level;

529.29 (3) be available in alternative formats and through auxiliary aids and services that consider
529.30 the special needs of the enrollee, including an enrollee with a disability or limited English
529.31 proficiency;

530.1 (4) use taglines that consist of short statements in each of the prevalent non-English
530.2 languages, in an 18-point font, that explain the availability of language interpreter services
530.3 free of charge; and

530.4 (5) explain how to request auxiliary aids and services, including the provision of the
530.5 materials in alternative formats and the TTY/TDY telephone number of the managed care
530.6 organization's customer service unit and the department's enrollee support system.

530.7 (e) For purposes of this subdivision, "prevalent non-English language" means a
530.8 non-English language that is determined by the commissioner to be spoken by a significant
530.9 number or percentage of potential enrollees and enrollees with limited proficiency in English.

530.10 Subd. 5. **Enrollee communication.** (a) The commissioner shall ensure that the managed
530.11 care organization:

530.12 (1) submits all marketing materials to the commissioner for approval before distribution
530.13 and that marketing materials are accurate and do not mislead, confuse, or defraud;

530.14 (2) distributes marketing materials to a managed care organization's entire service area
530.15 and as otherwise permitted by contract;

530.16 (3) complies with the information requirements in Code of Federal Regulations, part 42,
530.17 section 438.10;

530.18 (4) does not seek to influence enrollment with the sale or offering of any private
530.19 insurance, with the exception of communications between an enrollee and a managed care
530.20 organization that is related to the offering of a qualified health plan as defined under section
530.21 62K.03; and

530.22 (5) does not directly, or indirectly, engage in door-to-door, telephone, e-mail, texting,
530.23 or other cold-call marketing activities.

530.24 (b) For the purposes of this subdivision, "cold-call marketing activities" means any
530.25 unsolicited personal contact or communication by a managed care organization with an
530.26 individual who is not enrolled in that managed care organization that can be reasonably
530.27 interpreted as intended to influence the individual to enroll in a specific managed care
530.28 organization or to not enroll in or disenroll from another managed care organization.

530.29 Sec. 5. **[256B.6926] STATE MONITORING.**

530.30 Subdivision 1. **Generally.** (a) The commissioner shall establish a monitoring system
530.31 that addresses all aspects of the managed care program, including the performance of each

531.1 managed care organization in the areas identified under Code of Federal Regulations, part
531.2 42, section 438.66, paragraph (b).

531.3 (b) The commissioner shall use data collected from the monitoring activities, including,
531.4 at a minimum, the data identified in Code of Federal Regulations, part 42, section 438.66,
531.5 paragraph (c), to improve the performance of the managed care program.

531.6 Subd. 2. **Readiness review.** The commissioner shall conduct a readiness review of each
531.7 managed care organization that contracts with the commissioner to assess the managed care
531.8 organization's ability and capacity to perform satisfactorily in the areas described in Code
531.9 of Federal Regulations, part 42, section 438.66, paragraph (d), clauses (1) to (4). The review
531.10 must be conducted and approval must be received from the Centers for Medicare and
531.11 Medicaid Services prior to the commissioner entering into a contract with the managed care
531.12 organization.

531.13 Subd. 3. **Report.** (a) The commissioner shall submit to the Centers for Medicare and
531.14 Medicaid Services, no later than 180 days after each contract year, a report on the managed
531.15 care program administered by the commissioner, regardless of the authority under which
531.16 the program operates, with the initial report being submitted 180 days after the contract
531.17 year following the release of the Centers for Medicare and Medicaid Services guidance.
531.18 Each report must, at a minimum, assess the managed care program's operation in the areas
531.19 identified in Code of Federal Regulations, part 42, section 438.66, paragraph (e), clause
531.20 (2), and must be:

531.21 (1) provided to the Medicaid Citizens' Advisory Committee as required under Code of
531.22 Federal Regulations, part 42, section 431.12;

531.23 (2) provided to the stakeholder consultation group as required under Code of Federal
531.24 Regulations, part 42, section 438.70, to the extent the managed care program includes
531.25 long-term services and supports; and

531.26 (3) published on the department's Web site.

531.27 (b) The report described under this subdivision may be used to meet the commissioner's
531.28 reporting obligation under the managed care waiver authority for the managed care program.

531.29 Subd. 4. **Conflicts of interest.** The commissioner shall implement safeguards against
531.30 conflicts of interest on behalf of state and local officers and employees and agents of the
531.31 state who have responsibilities relating to managed care contracts. The safeguards must be
531.32 at least as effective as the safeguards specified in United States Code, title 41, sections 2101
531.33 to 2107. The commissioner shall comply with Code of Federal Regulations, part 42, section

532.1 438.58, and United States Code, title 42, section 1396a, paragraph (a), clause (4), item (c),
532.2 applicable to contracting officers, employees, or independent contractors.

532.3 **Sec. 6. [256B.6927] QUALITY ASSESSMENT AND PERFORMANCE.**

532.4 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
532.5 the meanings given them.

532.6 (b) "Access" means the availability and timely use of services to achieve optimal
532.7 outcomes as required under Code of Federal Regulations, part 42, sections 438.68 and
532.8 438.206.

532.9 (c) "External quality review" means the analysis and evaluation by an external quality
532.10 review organization of the aggregated information on quality, timeliness, and access to the
532.11 health care services that a managed care organization or the managed care organization's
532.12 contractor provides to enrollees.

532.13 (d) "External quality review organization" means an organization that meets the
532.14 competence and independence requirements under Code of Federal Regulations, part 42,
532.15 section 438.354, and performs external quality review and may perform other external
532.16 quality review-related activities as required under Code of Federal Regulations, part 42,
532.17 section 438.358.

532.18 (e) "Quality" means the degree that a managed care organization increases the likelihood
532.19 of desired outcomes of a managed care organization's enrollees through:

532.20 (1) a managed care organization's structural and operational characteristics;

532.21 (2) the provision of services that are consistent with current professional, evidence-based
532.22 knowledge; and

532.23 (3) interventions for performance improvement.

532.24 (f) "Validation" means the review of information, data, and procedures to determine the
532.25 extent that information, data, and procedures are accurate, reliable, free from bias, and
532.26 according to standards for data collection and analysis.

532.27 Subd. 2. **Quality strategy.** (a) The commissioner shall implement a written quality
532.28 strategy for assessing and improving the quality of health care and other services provided
532.29 by managed care organizations. At a minimum, the quality strategy must include:

532.30 (1) defined network adequacy requirements and availability of services standards for
532.31 managed care organizations, including examples of evidence-based clinical practice
532.32 guidelines;

- 533.1 (2) measurable goals and objectives for continuous quality improvement that consider
533.2 the health status of all populations served by the managed care organization;
- 533.3 (3) a description of:
- 533.4 (i) the quality metrics and performance targets used in measuring the performance and
533.5 improvement of each managed care organization; and
- 533.6 (ii) performance improvement projects, including a description of any intervention
533.7 proposed by the commissioner to improve access, quality, or timeliness of care for enrollees;
- 533.8 (4) annual, external independent reviews of quality outcomes, and the timeliness of and
533.9 access to services covered by the managed care organization;
- 533.10 (5) a description of the managed care organization's transition of care policy;
- 533.11 (6) a plan to identify, evaluate, and reduce health disparities based on an enrollee's age,
533.12 race, ethnicity, sex, primary language, or disability status, and provide this demographic
533.13 information to the managed care organization at the time of enrollment;
- 533.14 (7) appropriate use of intermediate sanctions to be imposed on a managed care
533.15 organization;
- 533.16 (8) the mechanisms implemented to identify enrollees who need long-term services and
533.17 supports or enrollees with special health care needs; and
- 533.18 (9) information related to nonduplication of the external quality review activities in
533.19 accordance with Code of Federal Regulations, part 42, section 438.360, paragraph (c).
- 533.20 (b) In developing the initial quality strategy, the commissioner shall:
- 533.21 (1) obtain input from the Medicaid Citizens' Advisory Committee, enrollees, and other
533.22 interested stakeholders;
- 533.23 (2) consult with the tribes according to the tribal consultation policy;
- 533.24 (3) consider recommendations from the external quality review organization identified
533.25 under subdivision 3, for improving the quality of health care services furnished by the
533.26 managed care organization; and
- 533.27 (4) make the strategy available for public comment.
- 533.28 (c) The commissioner shall submit a copy of the initial quality strategy to the Centers
533.29 for Medicare and Medicaid Services for comments and feedback. If significant changes are
533.30 made based on the comments and feedback received, the commissioner shall publish the

534.1 revised quality strategy on the department's Web site. The commissioner shall make the
534.2 final quality strategy available on the department's Web site.

534.3 (d) The commissioner shall review and update the quality strategy at least every three
534.4 years or more frequently, if needed. The review shall include an evaluation of the
534.5 effectiveness of the quality strategy conducted within the previous three years. The results
534.6 of the review and any updates shall be published on the department's Web site.

534.7 Subd. 3. **External quality reviews.** (a) The commissioner shall contract with an external
534.8 quality review organization in accordance with Code of Federal Regulations, part 42, section
534.9 438.354, to conduct an annual external quality review of each managed care organization.
534.10 The commissioner shall ensure that all necessary information is provided to the external
534.11 quality review organization for analysis and inclusion in the external quality review technical
534.12 report required under paragraph (g). The information provided must be obtained in
534.13 accordance with Code of Federal Regulations, part 42, section 438.352.

534.14 (b) The commissioner shall follow an open, competitive procurement process according
534.15 to state and federal law for any contract with an external quality review organization. The
534.16 external quality review organization may use a subcontractor if the subcontractor meets the
534.17 requirements for independence. The external quality review organization is accountable for
534.18 and must oversee all functions performed by the subcontractor.

534.19 (c) The following mandatory external quality review related activities must be performed
534.20 for each managed care organization:

534.21 (1) validation of performance improvement projects, performance measures, and meeting
534.22 network adequacy requirements for the 12 months preceding the most recently completed
534.23 contract period; and

534.24 (2) review of the managed care organization's compliance with Code of Federal
534.25 Regulations, part 42, subpart D, and section 438.330 for the preceding three years.

534.26 (d) The commissioner may elect to incorporate any of the optional activities listed in
534.27 Code of Federal Regulations, part 42, section 438.358, paragraph (c), as part of the external
534.28 quality review.

534.29 (e) To avoid duplication, the commissioner may use information from a Medicare or
534.30 private accreditation review to provide information for a managed care organization's annual
534.31 external quality review instead of conducting one or more of the mandatory external quality
534.32 review activities. The information used must satisfy Code of Federal Regulations, part 42,
534.33 section 438.360, paragraph (a).

535.1 (f) If the conditions in Code of Federal Regulations, part 42, section 438.362, are satisfied,
535.2 the commissioner may accept the data, correspondence, information, and findings regarding
535.3 the managed care organization's compliance with a Medicare quality review in lieu of
535.4 performing an external quality review. For each managed care organization exempt from
535.5 an external quality review, the commissioner shall obtain the most recent Medicare review
535.6 findings or Medicare information from a private national accrediting organization that the
535.7 Centers for Medicare and Medicaid Services approves and recognizes for Medicare
535.8 Advantage Organization deeming.

535.9 (g) The qualified external quality review organization must produce an annual external
535.10 quality review technical report in accordance with Code of Federal Regulations, part 42,
535.11 section 438.364. The technical report must summarize findings on access and quality of
535.12 care. The commissioner may revise the final external quality review technical report if there
535.13 is evidence of error or omission. The final external quality review technical report must be
535.14 published on the department's Web site by April 30 of each year and copies of the report
535.15 must be made available upon request and in alternative formats. Information in the technical
535.16 report must not disclose the identity or other protected patient identifying health information.

535.17 **Sec. 7. [256B.6928] MANAGED CARE RATES AND PAYMENTS.**

535.18 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
535.19 the meanings given them.

535.20 (b) "Base amount" has the meaning given in Code of Federal Regulations, part 42, section
535.21 438.6, paragraph (a).

535.22 (c) "Budget neutral" has the meaning given in Code of Federal Regulations, part 42,
535.23 section 438.5, paragraph (a).

535.24 (d) "Credibility adjustment" has the meaning given in Code of Federal Regulations, part
535.25 42, section 438.8, paragraph (b).

535.26 (e) "Full credibility" has the meaning given in Code of Federal Regulations, part 42,
535.27 section 438.8, paragraph (b).

535.28 (f) "Incentive arrangement" has the meaning given in Code of Federal Regulations, part
535.29 42, section 438.6.

535.30 (g) "Medical loss ratio" has the meaning given in Code of Federal Regulations, part 42,
535.31 section 438.8, paragraph (b).

536.1 (h) "Medical loss ratio reporting year" has the meaning given in Code of Federal
536.2 Regulations, part 42, section 438.8, paragraph (b).

536.3 (i) "Member months" has the meaning given in Code of Federal Regulations, part 42,
536.4 section 438.8, paragraph (b).

536.5 (j) "No credibility" has the meaning given in Code of Federal Regulations, part 42,
536.6 section 438.8, paragraph (b).

536.7 (k) "Partial credibility" has the meaning given in Code of Federal Regulations, part 42,
536.8 section 438.8, paragraph (b).

536.9 (l) "Pass-through payment" has the meaning given in Code of Federal Regulations, part
536.10 42, section 438.6, paragraph (a).

536.11 (m) "Rate cell" has the meaning given in Code of Federal Regulations, part 42, section
536.12 438.2.

536.13 (n) "Risk adjustment" has the meaning given in Code of Federal Regulations, part 42,
536.14 section 438.5, paragraph (a).

536.15 Subd. 2. **Actuarial soundness.** (a) Capitation rates for managed care organizations must
536.16 be reviewed and approved by the Centers for Medicare and Medicaid Services as actuarially
536.17 sound. The capitation rates must be provided in the format and time frame required by Code
536.18 of Federal Regulations, part 42, section 438.7. Capitation rates must:

536.19 (1) be developed in accordance with the rates standards in Code of Federal Regulations,
536.20 part 42, section 438.5, and generally accepted actuarial principles and practices. Any proposed
536.21 differences in capitation rates between covered populations must be based on valid rate
536.22 development standards and not on the rate of federal financial participation associated with
536.23 the covered populations;

536.24 (2) be appropriate for the populations covered and the services furnished under the
536.25 contract;

536.26 (3) meet the requirements for availability of services, adequate capacity, and coordination
536.27 and continuity of care in accordance with Code of Federal Regulations, part 42, sections
536.28 438.206, 438.207, and 438.208;

536.29 (4) be specific to each rate cell under the contract, and must not cross-subsidize or be
536.30 cross-subsidized by payments from any other rate cell;

536.31 (5) meet any special contract provisions in accordance with Code of Federal Regulations,
536.32 part 42, section 438.6; and

537.1 (6) be developed to reasonably achieve a medical loss ratio standard of at least 85 percent
537.2 for the rate year, or a higher minimum medical loss ratio if mandated by the commissioner,
537.3 as long as the capitation rates are adequate for reasonable, appropriate, and attainable
537.4 nonbenefit costs.

537.5 (b) An independent actuary must certify that the rates were developed in accordance
537.6 with Code of Federal Regulations, part 42, section 438.3, paragraph (c), clause (1), item
537.7 (ii), paragraph (e).

537.8 Subd. 3. **Rate development standards.** (a) In developing capitation rates, the
537.9 commissioner shall:

537.10 (1) identify and develop base utilization and price data, including validated encounter
537.11 data and audited financial reports received from the managed care organizations that
537.12 demonstrate experience for the populations served by the managed care organizations, for
537.13 the three most recent and complete years before the rating period;

537.14 (2) develop and apply reasonable trend factors, including cost and utilization, to base
537.15 data that are developed from actual experience of the medical assistance population or a
537.16 similar population according to generally accepted actuarial practices and principles;

537.17 (3) develop the nonbenefit component of the rate to account for reasonable expenses
537.18 related to the managed care organization's administration; taxes; licensing and regulatory
537.19 fees; contribution to reserves; risk margin; cost of capital and other operational costs
537.20 associated with the managed care organization's provision of covered services to enrollees;

537.21 (4) consider the value of cost-sharing for rate development purposes, regardless of
537.22 whether the managed care organization imposes the cost-sharing on the enrollee or the
537.23 cost-sharing is collected by the provider;

537.24 (5) make appropriate and reasonable adjustments to account for changes to the base data,
537.25 programmatic changes, changes to nonbenefit components, and any other adjustment
537.26 necessary to establish actuarially sound rates. Each adjustment must reasonably support the
537.27 development of an accurate base data set for purposes of rate setting, reflect the health status
537.28 of the enrolled population, and be developed in accordance with generally accepted actuarial
537.29 principles and practices;

537.30 (6) consider the managed care organization's past medical loss ratio in the development
537.31 of the capitation rates and consider the projected medical loss ratio; and

538.1 (7) select a prospective or retrospective risk adjustment methodology that must be
538.2 developed in a budget-neutral manner consistent with generally accepted actuarial principles
538.3 and practices.

538.4 (b) The base data must be derived from the medical assistance population or, if data on
538.5 the medical assistance population is not available, derived from a similar population and
538.6 adjusted to make the utilization and price data comparable to the medical assistance
538.7 population. Data must be in accordance with actuarial standards for data quality and an
538.8 explanation of why that specific data is used must be provided in the rate certification. If
538.9 the commissioner is unable to base the rates on data that are within the three most recent
538.10 and complete years before the rating period, the commissioner may request an approval
538.11 from the Centers for Medicare and Medicaid Services for an exception. The request must
538.12 describe why an exception is necessary and describe the actions that the commissioner
538.13 intends to take to comply with the request.

538.14 Subd. 4. **Special contract requirements related to payment.** (a) If the commissioner
538.15 uses risk-sharing mechanisms, including reinsurance, risk corridors, or stop-loss limits, the
538.16 risk-sharing mechanism must be described in the contract, and must be developed according
538.17 to the rate development standards and generally accepted actuarial principles and practices.

538.18 (b) The commissioner may utilize incentive payment arrangements in managed care
538.19 organization contracts. Any incentive arrangement utilized by the commissioner must be
538.20 made available to all managed care organizations under contract with the commissioner
538.21 under the same terms of performance. The payment must not exceed 105 percent of the
538.22 approved capitation payments attributable to the enrollees or services covered by the incentive
538.23 arrangement and must be actuarially sound. For all incentive arrangements the contract
538.24 must state that the arrangement is:

538.25 (1) for a fixed period of time and performance is measured during the rating period in
538.26 which the incentive arrangement is applied;

538.27 (2) not renewed automatically; and

538.28 (3) associated with specified activities, targets, performance measures, or quality-based
538.29 outcomes in the quality strategy described under section 256B.6927.

538.30 The incentive payment arrangement must not condition a managed care organization's
538.31 participation in the incentive arrangement upon entering into or adhering to an
538.32 intergovernmental transfer agreement.

539.1 (c) The commissioner may utilize withhold arrangements in managed care organization
539.2 contracts. Any withhold arrangement utilized by the commissioner must be applied to all
539.3 managed care organizations under contract with the commissioner under the same terms of
539.4 performance. Any withhold arrangement must ensure that the capitation payment minus
539.5 any portion of the withheld funds that is not reasonably achievable is actuarially sound. The
539.6 total amount of the withheld funds, achievable or not, must be reasonable and must take
539.7 into consideration each managed care organization's financial operating needs, accounting
539.8 for the size and characteristics of the populations covered under the contract, as well as the
539.9 managed care organization's capital reserves, as measured by the risk based capital level,
539.10 months of claims reserve, or other appropriate measure of reserves. The data, assumptions,
539.11 and methodologies used to determine the portion of the withhold that is reasonably achievable
539.12 must be submitted as part of the documentation required by Code of Federal Regulations,
539.13 part 42, section 438.7, paragraph (b), clause (6). For all withhold arrangements, the contract
539.14 must state that the arrangement is:

539.15 (1) for a fixed period of time and performance is measured during the rating period in
539.16 which the withhold arrangement is applied;

539.17 (2) not renewed automatically; and

539.18 (3) associated with specified activities, targets, performance measures, or quality-based
539.19 outcomes in the state's quality strategy.

539.20 The withhold payment arrangement must not condition a managed care organization's
539.21 participation in the withhold arrangement upon entering into or adhering to an
539.22 intergovernmental transfer agreement.

539.23 Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner
539.24 shall not direct managed care organizations expenditures under the managed care contract,
539.25 except in the following situations:

539.26 (1) implementation of a value-based purchasing model for provider reimbursement,
539.27 including pay-for-performance arrangements, bundled payments, or other service payments
539.28 intended to recognize value or outcomes over volume of services;

539.29 (2) participation in a multipayer or medical assistance-specific delivery system reform
539.30 or performance improvement initiative; or

539.31 (3) implementation of a minimum or maximum fee schedule, or a uniform dollar or
539.32 percentage increase for network providers that provide a particular service. The maximum

540.1 fee schedule must allow the managed care organization the ability to reasonably manage
540.2 risk and provide discretion in accomplishing the goals of the contract.

540.3 (b) Any managed care contract that directs managed care organization expenditures as
540.4 permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with
540.5 Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial
540.6 soundness and generally accepted actuarial principles and practices; and have written
540.7 approval from the Centers for Medicare and Medicaid Services before implementation. To
540.8 obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

540.9 (1) is based on the utilization and delivery of services;

540.10 (2) directs expenditures equally, using the same terms of performance for a class of
540.11 providers providing service under the contract;

540.12 (3) is intended to advance at least one of the goals and objectives in the commissioner's
540.13 quality strategy;

540.14 (4) has an evaluation plan that measures the degree to which the arrangement advances
540.15 at least one of the goals in the commissioner's quality strategy;

540.16 (5) does not condition network provider participation on the network provider entering
540.17 into or adhering to an intergovernmental transfer agreement; and

540.18 (6) is not renewed automatically.

540.19 (c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the
540.20 commissioner shall:

540.21 (1) make participation in the value-based purchasing model, special delivery system
540.22 reform, or performance improvement initiative available, using the same terms of
540.23 performance, to a class of providers providing services under the contract related to the
540.24 model, reform, or initiative; and

540.25 (2) use a common set of performance measures across all payers and providers.

540.26 (d) The commissioner shall not set the amount or frequency of the expenditures or recoup
540.27 from the managed care organization any unspent funds allocated for these arrangements.

540.28 **Subd. 6. Monthly capitation payments for placements in institutions of mental**
540.29 **disease.** The commissioner may make a monthly capitation payment to a managed care
540.30 organization for an enrollee under the age of 65 receiving treatment for psychiatric or
540.31 substance use disorder in an institution for mental diseases in accordance with Code of
540.32 Federal Regulations, part 42, section 438.6, paragraph (e).

541.1 Subd. 7. Rate certification submission. (a) The commissioner shall submit the rate
541.2 certifications to the Centers for Medicare and Medicaid Services for review and approval
541.3 at the same time as the managed care contracts. The rate certification must satisfy Code of
541.4 Federal Regulations, part 42, section 438.7, paragraph (b), and must include:

541.5 (1) base data used in the rate setting process;

541.6 (2) trend, including changes in the utilization and the price of services;

541.7 (3) the nonbenefit component of the rate;

541.8 (4) any adjustments;

541.9 (5) the prospective and retrospective risk adjustment methodology; and

541.10 (6) any special contract provisions related to payment.

541.11 (b) The commissioner, through the state's actuary, must certify the final capitation rates
541.12 paid per rate cell under each contract and document the underlying data, assumptions and
541.13 methodologies.

541.14 (c) The commissioner may pay a managed care organization a capitation rate under a
541.15 managed care contract that is different than the capitation rate paid to another managed care
541.16 organization, if each capitation rate per rate cell that is paid is independently developed and
541.17 set in accordance with Code of Federal Regulations, part 42, sections 438.4, 438.5, 438.6,
541.18 and 438.8. The commissioner may increase or decrease the capitation rate per rate cell in
541.19 accordance with Code of Federal Regulations, part 42, sections 438.4, paragraph (b), clause
541.20 (4), and 438.7, paragraph (c), up to 1.5 percent without submitting a revised rate certification.

541.21 (d) If the commissioner determines that a retroactive adjustment to the capitation rate
541.22 is necessary, the retroactive adjustment must be supported by a rationale for the adjustment
541.23 and the data. Assumptions and methodologies used to develop the adjustment must be
541.24 described with enough detail to allow the Centers for Medicare and Medicaid Services or
541.25 an actuary to determine the reasonableness of the adjustment. Any retroactive adjustments
541.26 must be certified by an actuary in a revised rate certification and submitted to the Centers
541.27 for Medicare and Medicaid Services for approval as a contract amendment. All adjustments
541.28 are subject to timely federal claim filing requirements.

541.29 (e) The commissioner shall, upon request from the Centers for Medicare and Medicaid
541.30 Services, provide additional information if the Centers for Medicare and Medicaid Services
541.31 determines the information is pertinent to certification approval. The commissioner shall
541.32 identify whether the additional information shall be provided by the commissioner, the
541.33 actuary, or another party.

542.1 Subd. 8. **Medical loss ratio.** (a) The commissioner shall require that each managed care
542.2 organization calculate and submit to the commissioner a medical loss ratio report for each
542.3 contract year. The calculation of the medical loss ratio in the medical loss ratio reporting
542.4 year must be the ratio of the numerator to the denominator. The numerator must be the sum
542.5 of the managed care organization's incurred claims, the managed care organization's
542.6 expenditures for activities that improve health care quality, and fraud prevention activities.
542.7 The denominator must be calculated as the managed care organization's adjusted premium
542.8 revenue minus the managed care organization's federal, state, and local taxes and licensing
542.9 and regulatory fees identified in Code of Federal Regulations, part 42, section 438.8,
542.10 paragraph (f), clause (3). The total amount of the denominator for a managed care
542.11 organization that is assumed by another managed care organization must be reported by the
542.12 assuming managed care organization for the entire medical loss ratio reporting year. The
542.13 managed care organization must aggregate the data for all eligibility groups covered under
542.14 the contract, unless the commissioner requires separate reporting and a separate medical
542.15 loss ratio calculation for specific populations.

542.16 (b) Incurred claims must be identified by the expenditures, liabilities, reserves, deductions,
542.17 and exclusions in accordance with Code of Federal Regulations, part 42, section 438.8,
542.18 paragraph (e), clause (2).

542.19 (c) Activities that improve health care quality must be in one category in accordance
542.20 with Code of Federal Regulations, part 42, section 438.8, paragraph (e), clause (3).

542.21 (d) Fraud prevention activities, including managed care organization expenditures on
542.22 activities related to fraud prevention must be identified in accordance with Code of Federal
542.23 Regulations, part 45, section 158.

542.24 (e) Premium revenue must include capitation payments; onetime payments for specific
542.25 life events of enrollees; other payments to the managed care organization in accordance
542.26 with Code of Federal Regulations, part 42, section 438.6, paragraph (b), clause (3); unpaid
542.27 cost-sharing amounts; and changes to unearned premium reserves, net payments, and receipts
542.28 related to risk-sharing mechanisms.

542.29 (f) When calculating the medical loss ratio, each expense must be included under only
542.30 one type of expense, unless a portion of the expense fits under the definition of, or criteria
542.31 for, one type of expense and the remainder fits into a different type of expense, in which
542.32 case the expense must be prorated between types of expenses. Expenditures that benefit
542.33 multiple contracts or populations, or contracts other than those being reported, must be

543.1 reported on a pro rata basis. Expenses must be allocated using the methods described in
543.2 Code of Federal Regulations, part 42, section 438.8, paragraph (g), clause (2).

543.3 (g) The commissioner may require the managed care organization to provide a remittance
543.4 if the medical loss ratio for the medical loss ratio reporting year does not meet the minimum
543.5 medical loss ratio standard of 85 percent, or if applicable, a higher ratio mandated by the
543.6 commissioner.

543.7 Subd. 9. **Reports.** (a) The commissioner shall require each managed care organization
543.8 to submit a report to the commissioner for each medical loss ratio reporting year that includes
543.9 the information identified in Code of Federal Regulations, part 42, section 438.8, paragraph
543.10 (k). The report must be submitted within 12 months of the end of each medical loss ratio
543.11 reporting year. The managed care organization must require any third-party vendor providing
543.12 claims adjudication to provide all underlying data associated with medical loss ratio reporting
543.13 to the managed care organization within 180 days of the end of the medical loss ratio
543.14 reporting year or within 30 days of being requested by the managed care organization to
543.15 calculate and validate the accuracy of medical loss ratio reporting. The managed care
543.16 organization must include with the medical loss ratio report an attestation as to the accuracy
543.17 of the calculation of the medical loss ratio.

543.18 (b) The commissioner shall annually submit to the Centers for Medicare and Medicaid
543.19 Services a summary description of the reports received from the managed care organizations
543.20 in accordance with Code of Federal Regulations, part 42, section 438.8, paragraph (k), along
543.21 with the rate certification required under subdivision 7. At a minimum, the summary
543.22 description must include for the medical loss ratio report reporting year, the amount of the
543.23 numerator, the amount of the denominator, the medical loss ratio percentage achieved, the
543.24 number of member months, and any remittances owed. If through the contract the
543.25 commissioner requires the managed care organization to pay remittances for not meeting
543.26 the minimum medical loss ratio, the commissioner must reimburse the Centers for Medicare
543.27 and Medicaid Services the federal share that reflects any differences in the federal matching
543.28 rate. If a remittance is owed, the commissioner shall submit with the required report a
543.29 separate report describing the methodology used to determine the state and federal shares
543.30 of the remittance.

543.31 (c) If the commissioner makes a retroactive change to the capitation payments for a
543.32 medical loss ratio reporting year for which the report was already submitted to the
543.33 commissioner, the managed care organization shall recalculate the medical loss ratio for
543.34 that year and submit a new report meeting the reporting requirements under paragraph (a).

544.1 (d) The commissioner may exempt a newly contracted managed care organization from
544.2 calculating and reporting the medical loss ratio for the first year of the managed care
544.3 organization's operation as required under this subdivision. If a managed care organization
544.4 is excluded, the managed care organization must comply with the requirements of this
544.5 section during the next medical loss ratio reporting year.

544.6 **ARTICLE 16**

544.7 **CHILD CARE DEVELOPMENT BLOCK GRANT COMPLIANCE**

544.8 Section 1. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

544.9 Subd. 4. **Inspections; waiver.** (a) Before issuing an initial license, the commissioner
544.10 shall conduct an inspection of the program. The inspection must include but is not limited
544.11 to:

544.12 (1) an inspection of the physical plant;

544.13 (2) an inspection of records and documents;

544.14 (3) an evaluation of the program by consumers of the program; ~~and~~

544.15 (4) observation of the program in operation; and

544.16 (5) an inspection for the health, safety, and fire standards in licensing requirements for
544.17 a child care license holder.

544.18 For the purposes of this subdivision, "consumer" means a person who receives the
544.19 services of a licensed program, the person's legal guardian, or the parent or individual having
544.20 legal custody of a child who receives the services of a licensed program.

544.21 (b) The evaluation required in paragraph (a), clause (3) or the observation in paragraph
544.22 (a), clause (4) is not required prior to issuing an initial license under subdivision 7. If the
544.23 commissioner issues an initial license under subdivision 7, these requirements must be
544.24 completed within one year after the issuance of an initial license.

544.25 (c) The commissioner or the county shall inspect at least annually a child care provider
544.26 licensed under this chapter and Minnesota Rules, chapter 9502 or 9503, for compliance
544.27 with applicable licensing standards.

544.28 (d) No later than November 19, 2017, the commissioner shall make publicly available
544.29 on the department's Web site the results of inspection reports of all child care providers
544.30 licensed under this chapter and under Minnesota Rules, chapter 9502 or 9503, and the

545.1 number of deaths, serious injuries, and instances of substantiated child maltreatment that
545.2 occurred in licensed child care settings each year.

545.3 **EFFECTIVE DATE.** This section is effective August 1, 2017.

545.4 Sec. 2. Minnesota Statutes 2016, section 245A.09, subdivision 7, is amended to read:

545.5 Subd. 7. **Regulatory methods.** (a) Where appropriate and feasible the commissioner
545.6 shall identify and implement alternative methods of regulation and enforcement to the extent
545.7 authorized in this subdivision. These methods shall include:

545.8 (1) expansion of the types and categories of licenses that may be granted;

545.9 (2) when the standards of another state or federal governmental agency or an independent
545.10 accreditation body have been shown to require the same standards, methods, or alternative
545.11 methods to achieve substantially the same intended outcomes as the licensing standards,
545.12 the commissioner shall consider compliance with the governmental or accreditation standards
545.13 to be equivalent to partial compliance with the licensing standards; and

545.14 (3) use of an abbreviated inspection that employs key standards that have been shown
545.15 to predict full compliance with the rules.

545.16 (b) If the commissioner accepts accreditation as documentation of compliance with a
545.17 licensing standard under paragraph (a), the commissioner shall continue to investigate
545.18 complaints related to noncompliance with all licensing standards. The commissioner may
545.19 take a licensing action for noncompliance under this chapter and shall recognize all existing
545.20 appeal rights regarding any licensing actions taken under this chapter.

545.21 (c) The commissioner shall work with the commissioners of health, public safety,
545.22 administration, and education in consolidating duplicative licensing and certification rules
545.23 and standards if the commissioner determines that consolidation is administratively feasible,
545.24 would significantly reduce the cost of licensing, and would not reduce the protection given
545.25 to persons receiving services in licensed programs. Where administratively feasible and
545.26 appropriate, the commissioner shall work with the commissioners of health, public safety,
545.27 administration, and education in conducting joint agency inspections of programs.

545.28 (d) The commissioner shall work with the commissioners of health, public safety,
545.29 administration, and education in establishing a single point of application for applicants
545.30 who are required to obtain concurrent licensure from more than one of the commissioners
545.31 listed in this clause.

546.1 (e) Unless otherwise specified in statute, the commissioner may conduct routine
546.2 inspections biennially.

546.3 (f) For a licensed child care center, the commissioner shall conduct one unannounced
546.4 licensing inspection at least annually.

546.5 **EFFECTIVE DATE.** This section is effective August 1, 2017.

546.6 Sec. 3. Minnesota Statutes 2016, section 245A.10, subdivision 2, is amended to read:

546.7 Subd. 2. **County fees for background studies and licensing inspections.** (a) Before
546.8 the implementation of NETStudy 2.0, for purposes of family and group family child care
546.9 licensing under this chapter, a county agency may charge a fee to an applicant or license
546.10 holder to recover the actual cost of background studies, but in any case not to exceed \$100
546.11 annually. A county agency may also charge a license fee to an applicant or license holder
546.12 not to exceed \$50 for a one-year license or \$100 for a two-year license.

546.13 (b) Before the implementation of NETStudy 2.0, a county agency may charge a fee to
546.14 a legal nonlicensed child care provider or applicant for authorization to recover the actual
546.15 cost of background studies completed under section 119B.125, but in any case not to exceed
546.16 \$100 annually.

546.17 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

546.18 (1) in cases of financial hardship;

546.19 (2) if the county has a shortage of providers in the county's area;

546.20 (3) for new providers; or

546.21 (4) for providers who have attained at least 16 hours of training before seeking initial
546.22 licensure.

546.23 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an
546.24 installment basis for up to one year. If the provider is receiving child care assistance payments
546.25 from the state, the provider may have the fees under paragraph (a) or (b) deducted from the
546.26 child care assistance payments for up to one year and the state shall reimburse the county
546.27 for the county fees collected in this manner.

546.28 (e) For purposes of adult foster care and child foster care licensing, and licensing the
546.29 physical plant of a community residential setting, under this chapter, a county agency may
546.30 charge a fee to a corporate applicant or corporate license holder to recover the actual cost
546.31 of licensing inspections, not to exceed \$500 annually.

547.1 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the following
547.2 circumstances:

547.3 (1) in cases of financial hardship;

547.4 (2) if the county has a shortage of providers in the county's area; or

547.5 (3) for new providers.

547.6 **EFFECTIVE DATE.** This section is effective August 1, 2017.

547.7 Sec. 4. Minnesota Statutes 2016, section 245A.14, is amended by adding a subdivision to
547.8 read:

547.9 **Subd. 15. Parental access in child care programs.** An enrolled child's parent or legal
547.10 guardian must be allowed access to the parent's or legal guardian's child any time while the
547.11 child is in care.

547.12 **EFFECTIVE DATE.** This section is effective August 1, 2017.

547.13 Sec. 5. Minnesota Statutes 2016, section 245A.16, subdivision 1, is amended to read:

547.14 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private
547.15 agencies that have been designated or licensed by the commissioner to perform licensing
547.16 functions and activities under section 245A.04 and background studies for family child care
547.17 under chapter 245C; to recommend denial of applicants under section 245A.05; to issue
547.18 correction orders, to issue variances, and recommend a conditional license under section
547.19 245A.06; or to recommend suspending or revoking a license or issuing a fine under section
547.20 245A.07, shall comply with rules and directives of the commissioner governing those
547.21 functions and with this section. The following variances are excluded from the delegation
547.22 of variance authority and may be issued only by the commissioner:

547.23 (1) dual licensure of family child care and child foster care, dual licensure of child and
547.24 adult foster care, and adult foster care and family child care;

547.25 (2) adult foster care maximum capacity;

547.26 (3) adult foster care minimum age requirement;

547.27 (4) child foster care maximum age requirement;

547.28 (5) variances regarding disqualified individuals except that, before the implementation
547.29 of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding
547.30 disqualified individuals when the county is responsible for conducting a consolidated

548.1 reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and
548.2 (b), of a county maltreatment determination and a disqualification based on serious or
548.3 recurring maltreatment;

548.4 (6) the required presence of a caregiver in the adult foster care residence during normal
548.5 sleeping hours; and

548.6 (7) variances to requirements relating to chemical use problems of a license holder or a
548.7 household member of a license holder.

548.8 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must
548.9 not grant a license holder a variance to exceed the maximum allowable family child care
548.10 license capacity of 14 children.

548.11 (b) Before the implementation of NETStudy 2.0, county agencies must report information
548.12 about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision
548.13 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the
548.14 commissioner at least monthly in a format prescribed by the commissioner.

548.15 (c) For family ~~day~~ child care programs, the commissioner ~~may authorize~~ shall require
548.16 a county agency to conduct one unannounced licensing reviews every two years after a
548.17 licensee has had at least one annual review at least annually.

548.18 (d) For family adult day services programs, the commissioner may authorize licensing
548.19 reviews every two years after a licensee has had at least one annual review.

548.20 (e) A license issued under this section may be issued for up to two years.

548.21 (f) During implementation of chapter 245D, the commissioner shall consider:

548.22 (1) the role of counties in quality assurance;

548.23 (2) the duties of county licensing staff; and

548.24 (3) the possible use of joint powers agreements, according to section 471.59, with counties
548.25 through which some licensing duties under chapter 245D may be delegated by the
548.26 commissioner to the counties.

548.27 Any consideration related to this paragraph must meet all of the requirements of the corrective
548.28 action plan ordered by the federal Centers for Medicare and Medicaid Services.

548.29 (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
548.30 successor provisions; and section 245D.061 or successor provisions, for family child foster
548.31 care programs providing out-of-home respite, as identified in section 245D.03, subdivision

549.1 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and
549.2 private agencies.

549.3 (h) A county agency shall report to the commissioner, in a manner prescribed by the
549.4 commissioner, the following information for a licensed family child care program:

549.5 (1) the results of each licensing review completed, including the date of the review, any
549.6 licensing correction order issued; and

549.7 (2) any death, serious injury, or determination of substantiated maltreatment.

549.8 **EFFECTIVE DATE.** This section is effective August 1, 2017.

549.9 Sec. 6. Minnesota Statutes 2016, section 245A.16, is amended by adding a subdivision to
549.10 read:

549.11 Subd. 7. **Family child care licensing oversight.** Only county staff trained by the
549.12 commissioner on the family child care licensing standards in this chapter and Minnesota
549.13 Rules, chapter 9502, shall perform family child care licensing functions under subdivision
549.14 1. Training must occur within 90 days of a staff person's employment.

549.15 **EFFECTIVE DATE.** This section is effective August 1, 2017.

549.16 Sec. 7. Minnesota Statutes 2016, section 245A.40, is amended by adding a subdivision to
549.17 read:

549.18 Subd. 9. **Ongoing health and safety training.** A staff person's orientation training on
549.19 maintaining health and safety and handling emergencies and accidents, as required in
549.20 subdivision 1, must be repeated at least once each calendar year by each staff person. The
549.21 completion of the annual training must be documented in the staff person's personnel record.

549.22 **EFFECTIVE DATE.** This section is effective August 1, 2017.

549.23 Sec. 8. **[245A.41] CHILD CARE CENTER HEALTH AND SAFETY**
549.24 **REQUIREMENTS.**

549.25 Subdivision 1. **Allergy prevention and response.** (a) Before admitting a child for care,
549.26 the license holder must obtain documentation of any known allergy from the child's parent
549.27 or legal guardian or the child's source of medical care. If a child has a known allergy, the
549.28 license holder must maintain current information about the allergy in the child's record and
549.29 develop an individual child care program plan as specified in Minnesota Rules, part
549.30 9503.0065, subpart 3. The individual child care program plan must include but not be limited
549.31 to a description of the allergy, specific triggers, avoidance techniques, symptoms of an

550.1 allergic reaction, and procedures for responding to an allergic reaction, including medication,
550.2 dosages, and a doctor's contact information.

550.3 (b) The license holder must ensure that each staff person who is responsible for carrying
550.4 out the individual child care program plan review and follow the plan. Documentation of a
550.5 staff person's review must be kept on site.

550.6 (c) At least annually or following any changes made to allergy-related information in
550.7 the child's record, the license holder must update the child's individual child care program
550.8 plan and inform each staff person who is responsible for carrying out the individual child
550.9 care program plan of the change. The license holder must keep on site documentation that
550.10 a staff person was informed of a change.

550.11 (d) A child's allergy information must be available at all times including on site, when
550.12 on field trips, or during transportation. A child's food allergy information must be readily
550.13 available to a staff person in the area where food is prepared and served to the child.

550.14 (e) The license holder must contact the child's parent or legal guardian as soon as possible
550.15 in any instance of exposure or allergic reaction that requires medication or medical
550.16 intervention. The license holder must call emergency medical services when epinephrine
550.17 is administered to a child in the license holder's care.

550.18 Subd. 2. **Handling and disposal of bodily fluids.** The licensed child care center must
550.19 comply with the following procedures for safely handling and disposing of bodily fluids:

550.20 (1) surfaces that come in contact with potentially infectious bodily fluids, including
550.21 blood and vomit, must be cleaned and disinfected according to Minnesota Rules, part
550.22 9503.0005, subpart 11;

550.23 (2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

550.24 (3) sharp items used for a child with special care needs must be disposed of in a "sharps
550.25 container." The sharps container must be stored out of reach of a child;

550.26 (4) the license holder must have the following bodily fluid disposal supplies in the center:
550.27 disposable gloves, disposal bags, and eye protection; and

550.28 (5) the license holder must ensure that each staff person is trained on universal precautions
550.29 to reduce the risk of spreading infectious disease. A staff person's completion of the training
550.30 must be documented in the staff person's personnel record.

550.31 Subd. 3. **Emergency preparedness.** (a) No later than September 30, 2017, a licensed
550.32 child care center must have a written emergency plan for emergencies that require evacuation,

551.1 sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other
551.2 threatening situation that may pose a health or safety hazard to a child. The plan must be
551.3 written on a form developed by the commissioner and must include:

551.4 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

551.5 (2) a designated relocation site and evacuation route;

551.6 (3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation,
551.7 shelter-in-place, or lockdown, including procedures for reunification with families;

551.8 (4) accommodations for a child with a disability or a chronic medical condition;

551.9 (5) procedures for storing a child's medically necessary medicine that facilitates easy
551.10 removal during an evacuation or relocation;

551.11 (6) procedures for continuing operations in the period during and after a crisis; and

551.12 (7) procedures for communicating with local emergency management officials, law
551.13 enforcement officials, or other appropriate state or local authorities.

551.14 (b) The license holder must train staff persons on the emergency plan at orientation,
551.15 when changes are made to the plan, and at least once each calendar year. Training must be
551.16 documented in each staff person's personnel file.

551.17 (c) The license holder must conduct drills according to the requirements in Minnesota
551.18 Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

551.19 (d) The license holder must review and update the emergency plan annually.
551.20 Documentation of the annual emergency plan review shall be maintained in the program's
551.21 administrative records.

551.22 (e) The license holder must include the emergency plan in the program's policies and
551.23 procedures as specified under section 245A.04, subdivision 14. The license holder must
551.24 provide a physical or electronic copy of the emergency plan to the child's parent or legal
551.25 guardian upon enrollment.

551.26 (f) The relocation site and evacuation route must be posted in a visible place as part of
551.27 the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140,
551.28 subpart 21.

552.1 Sec. 9. **[245A.51] FAMILY CHILD CARE HEALTH AND SAFETY**
552.2 **REQUIREMENTS.**

552.3 **Subdivision 1. Allergy prevention and response.** (a) Before admitting a child for care,
552.4 the license holder must obtain information about any known allergy from the child's parent
552.5 or legal guardian. The license holder must maintain current allergy information in each
552.6 child's record. The allergy information must include a description of the allergy, specific
552.7 triggers, avoidance techniques, symptoms of an allergic reaction, and procedures for
552.8 responding to an allergic reaction, including medication, dosages, and a doctor's contact
552.9 information.

552.10 (b) The child's allergy information must be documented on a form approved by the
552.11 commissioner, readily available to all caregivers, and reviewed annually by the license
552.12 holder and each caregiver.

552.13 **Subd. 2. Handling and disposal of bodily fluids.** The licensed family child care provider
552.14 must comply with the following procedures for safely handling and disposing of bodily
552.15 fluids:

552.16 (1) surfaces that come in contact with potentially infectious bodily fluids, including
552.17 blood and vomit, must be cleaned and disinfected as described in section 245A.148;

552.18 (2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

552.19 (3) sharp items used for a child with special care needs must be disposed of in a "sharps
552.20 container." The sharps container must be stored out of reach of a child; and

552.21 (4) the license holder must have the following bodily fluid disposal supplies available:
552.22 disposable gloves, disposal bags, and eye protection.

552.23 **Subd. 3. Emergency preparedness plan.** (a) No later than September 30, 2017, a
552.24 licensed family child care provider must have a written emergency preparedness plan for
552.25 emergencies that require evacuation, sheltering, or other protection of children, such as fire,
552.26 natural disaster, intruder, or other threatening situation that may pose a health or safety
552.27 hazard to children. The plan must be written on a form developed by the commissioner and
552.28 updated at least annually. The plan must include:

552.29 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

552.30 (2) a designated relocation site and evacuation route;

552.31 (3) procedures for notifying a child's parent or legal guardian of the evacuation,
552.32 shelter-in-place, or lockdown, including procedures for reunification with families;

553.1 (4) accommodations for a child with a disability or a chronic medical condition;

553.2 (5) procedures for storing a child's medically necessary medicine that facilitate easy
553.3 removal during an evacuation or relocation;

553.4 (6) procedures for continuing operations in the period during and after a crisis; and

553.5 (7) procedures for communicating with local emergency management officials, law
553.6 enforcement officials, or other appropriate state or local authorities.

553.7 (b) The license holder must train caregivers before the caregiver provides care and at
553.8 least annually on the emergency preparedness plan and document completion of this training.

553.9 (c) The license holder must conduct drills according to the requirements in Minnesota
553.10 Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

553.11 (d) The license holder must have the emergency preparedness plan available for review
553.12 and posted in a prominent location. The license holder must provide a physical or electronic
553.13 copy of the plan to the child's parent or legal guardian upon enrollment.

553.14 **EFFECTIVE DATE.** This section is effective August 1, 2017.

553.15 Sec. 10. Minnesota Statutes 2016, section 245C.02, is amended by adding a subdivision
553.16 to read:

553.17 Subd. 6a. **Child care staff person.** "Child care staff person" means an individual other
553.18 than an individual who is related to all children for whom child care services are provided
553.19 and:

553.20 (1) who is employed by a child care provider for compensation;

553.21 (2) whose activities involve the care or supervision of a child for a child care provider
553.22 or unsupervised access to a child who is cared for or supervised by a child care provider;

553.23 or

553.24 (3) an individual 13 years of age or older residing in a licensed family child care home
553.25 or legal nonlicensed child care program.

553.26 **EFFECTIVE DATE.** This section is effective October 1, 2017.

553.27 Sec. 11. Minnesota Statutes 2016, section 245C.03, subdivision 1, is amended to read:

553.28 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background
553.29 study on:

553.30 (1) the person or persons applying for a license;

554.1 (2) an individual age 13 and over living in the household where the licensed program
554.2 will be provided who is not receiving licensed services from the program;

554.3 (3) current or prospective employees or contractors of the applicant who will have direct
554.4 contact with persons served by the facility, agency, or program;

554.5 (4) volunteers or student volunteers who will have direct contact with persons served
554.6 by the program to provide program services if the contact is not under the continuous, direct
554.7 supervision by an individual listed in clause (1) or (3);

554.8 (5) an individual age ten to 12 living in the household where the licensed services will
554.9 be provided when the commissioner has reasonable cause;

554.10 (6) an individual who, without providing direct contact services at a licensed program,
554.11 may have unsupervised access to children or vulnerable adults receiving services from a
554.12 program, when the commissioner has reasonable cause; ~~and~~

554.13 (7) all ~~managerial officials~~ controlling individuals as defined ~~under~~ in section 245A.02,
554.14 subdivision 5a.; and

554.15 (8) child care staff persons as defined in section 245C.02, subdivision 6a.

554.16 (b) Paragraph (a), clauses (5) and (6), apply to legal nonlicensed child care and certified
554.17 license-exempt child care programs.

554.18 ~~(b)~~ (c) For family child foster care settings, a short-term substitute caregiver providing
554.19 direct contact services for a child for less than 72 hours of continuous care is not required
554.20 to receive a background study under this chapter.

554.21 **EFFECTIVE DATE.** This section is effective when the Department of Human Services
554.22 implements NETStudy 2.0 or October 1, 2017, whichever is later. The commissioner of
554.23 human services shall notify the revisor of statutes when the department implements
554.24 NETStudy 2.0.

554.25 Sec. 12. Minnesota Statutes 2016, section 245C.03, is amended by adding a subdivision
554.26 to read:

554.27 Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner
554.28 shall conduct background studies on an individual required under sections 119B.125 and
554.29 245G.10 to complete a background study under this chapter.

554.30 **EFFECTIVE DATE.** This section is effective October 1, 2017.

555.1 Sec. 13. Minnesota Statutes 2016, section 245C.04, subdivision 1, is amended to read:

555.2 Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner
555.3 shall conduct a background study of an individual required to be studied under section
555.4 245C.03, subdivision 1, at least upon application for initial license for all license types.

555.5 (b) The commissioner shall conduct a background study of an individual required to be
555.6 studied under section 245C.03, subdivision 1, including a child care staff person as defined
555.7 in section 245C.02, subdivision 6a, in a family child care program, licensed child care center,
555.8 certified license-exempt child care center, or legal nonlicensed child care provider, on a
555.9 schedule determined by the commissioner. The background study must include submission
555.10 of fingerprints for a national criminal history record check and a review of the information
555.11 under section 245C.08. A background study for a child care program must be repeated
555.12 within five years from the most recent study conducted under this paragraph.

555.13 (c) At reapplication ~~for a license~~ for a family child care license:

555.14 (1) for a background study affiliated with a licensed family child care center or legal
555.15 nonlicensed child care provider, the individual shall provide information required under
555.16 section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be
555.17 fingerprinted and photographed under section 245C.05, subdivision 5;

555.18 (2) the county agency shall verify the information received under clause (1) and forward
555.19 the information to the commissioner to complete the background study; and

555.20 (3) the background study conducted by the commissioner under this paragraph must
555.21 include a review of the information required under section 245C.08.

555.22 ~~(d)~~ (d) The commissioner is not required to conduct a study of an individual at the time
555.23 of reapplication for a license if the individual's background study was completed by the
555.24 commissioner of human services and the following conditions are met:

555.25 (1) a study of the individual was conducted either at the time of initial licensure or when
555.26 the individual became affiliated with the license holder;

555.27 (2) the individual has been continuously affiliated with the license holder since the last
555.28 study was conducted; and

555.29 (3) the last study of the individual was conducted on or after October 1, 1995.

555.30 ~~(d)~~ (e) The commissioner of human services shall conduct a background study of an
555.31 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6),
555.32 who is newly affiliated with a child foster care license holder. The county or private agency

556.1 shall collect and forward to the commissioner the information required under section 245C.05,
556.2 subdivisions 1 and 5. The background study conducted by the commissioner of human
556.3 services under this paragraph must include a review of the information required under
556.4 section 245C.08, subdivisions 1, 3, and 4.

556.5 ~~(e)~~ (f) The commissioner shall conduct a background study of an individual specified
556.6 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated
556.7 with an adult foster care or family adult day services and with a family child care license
556.8 holder or a legal nonlicensed child care provider authorized under chapter 119B: (1) the
556.9 county shall collect and forward to the commissioner the information required under section
556.10 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) ~~and~~ (b),
556.11 and (d), for background studies conducted by the commissioner for all family adult day
556.12 services ~~and~~ for adult foster care when the adult foster care license holder resides in the
556.13 adult foster care residence, and for family child care and legal nonlicensed child care
556.14 authorized under chapter 119B; (2) the license holder shall collect and forward to the
556.15 commissioner the information required under section 245C.05, subdivisions 1, paragraphs
556.16 (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the
556.17 commissioner for adult foster care when the license holder does not reside in the adult foster
556.18 care residence; and (3) the background study conducted by the commissioner under this
556.19 paragraph must include a review of the information required under section 245C.08,
556.20 subdivision 1, paragraph (a), and subdivisions 3 and 4.

556.21 ~~(f)~~ (g) Applicants for licensure, license holders, and other entities as provided in this
556.22 chapter must submit completed background study requests to the commissioner using the
556.23 electronic system known as NETStudy before individuals specified in section 245C.03,
556.24 subdivision 1, begin positions allowing direct contact in any licensed program.

556.25 ~~(g)~~ (h) For an individual who is not on the entity's active roster, the entity must initiate
556.26 a new background study through NETStudy when:

556.27 (1) an individual returns to a position requiring a background study following an absence
556.28 of 120 or more consecutive days; or

556.29 (2) a program that discontinued providing licensed direct contact services for 120 or
556.30 more consecutive days begins to provide direct contact licensed services again.

556.31 The license holder shall maintain a copy of the notification provided to the commissioner
556.32 under this paragraph in the program's files. If the individual's disqualification was previously
556.33 set aside for the license holder's program and the new background study results in no new

557.1 information that indicates the individual may pose a risk of harm to persons receiving
557.2 services from the license holder, the previous set-aside shall remain in effect.

557.3 ~~(h)~~ (i) For purposes of this section, a physician licensed under chapter 147 is considered
557.4 to be continuously affiliated upon the license holder's receipt from the commissioner of
557.5 health or human services of the physician's background study results.

557.6 ~~(i)~~ (j) For purposes of family child care, a substitute caregiver must receive repeat
557.7 background studies at the time of each license renewal.

557.8 (k) A repeat background study at the time of license renewal is not required if the family
557.9 child care substitute caregiver's background study was completed by the commissioner on
557.10 or after October 1, 2017, and the substitute caregiver is on the license holder's active roster
557.11 in NETStudy 2.0.

557.12 **EFFECTIVE DATE.** This section is effective October 1, 2017.

557.13 Sec. 14. Minnesota Statutes 2016, section 245C.04, subdivision 8, is amended to read:

557.14 Subd. 8. **Current or prospective contractors serving multiple family child care**
557.15 **license holders.** (a) Before the implementation of NETStudy 2.0, current or prospective
557.16 contractors who are required to have a background study under section 245C.03, subdivision
557.17 1, who provide services for multiple family child care license holders in a single county,
557.18 and will have direct contact with children served in the family child care setting are required
557.19 to have only one background study which is transferable to all family child care programs
557.20 in that county if:

557.21 (1) the county agency maintains a record of the contractor's background study results
557.22 which verify the contractor is approved to have direct contact with children receiving
557.23 services;

557.24 (2) the license holder contacts the county agency and obtains notice that the current or
557.25 prospective contractor is in compliance with background study requirements and approved
557.26 to have direct contact; and

557.27 (3) the contractor's background study is repeated every two years.

557.28 (b) For a family child care license holder operating under NETStudy 2.0, the license
557.29 holder's active roster shall be the system used to document when a background study subject
557.30 is affiliated with the license holder.

557.31 **EFFECTIVE DATE.** This section is effective August 1, 2017.

558.1 Sec. 15. Minnesota Statutes 2016, section 245C.05, subdivision 2b, is amended to read:

558.2 Subd. 2b. **County agency to collect and forward information to commissioner.** (a)
558.3 For background studies related to all family adult day services and to adult foster care when
558.4 the adult foster care license holder resides in the adult foster care residence, the county
558.5 agency must collect the information required under subdivision 1 and forward it to the
558.6 commissioner.

558.7 (b) Upon implementation of NETStudy 2.0, for background studies related to family
558.8 child care and legal nonlicensed child care authorized under chapter 119B, the county agency
558.9 must collect the information required under subdivision 1 and provide the information to
558.10 the commissioner.

558.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

558.12 Sec. 16. Minnesota Statutes 2016, section 245C.05, subdivision 4, is amended to read:

558.13 Subd. 4. **Electronic transmission.** (a) For background studies conducted by the
558.14 Department of Human Services, the commissioner shall implement a secure system for the
558.15 electronic transmission of:

558.16 (1) background study information to the commissioner;

558.17 (2) background study results to the license holder;

558.18 (3) background study results to county and private agencies for background studies
558.19 conducted by the commissioner for child foster care; and

558.20 (4) background study results to county agencies for background studies conducted by
558.21 the commissioner for adult foster care and family adult day services and, upon
558.22 implementation of NETStudy 2.0, family child care and legal nonlicensed child care
558.23 authorized under chapter 119B.

558.24 (b) Unless the commissioner has granted a hardship variance under paragraph (c), a
558.25 license holder or an applicant must use the electronic transmission system known as
558.26 NETStudy or NETStudy 2.0 to submit all requests for background studies to the
558.27 commissioner as required by this chapter.

558.28 (c) A license holder or applicant whose program is located in an area in which high-speed
558.29 Internet is inaccessible may request the commissioner to grant a variance to the electronic
558.30 transmission requirement.

558.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

559.1 Sec. 17. Minnesota Statutes 2016, section 245C.05, subdivision 5, is amended to read:

559.2 Subd. 5. **Fingerprints and photograph.** (a) Before the implementation of NETStudy
559.3 2.0, except as provided in paragraph (c), for any background study completed under this
559.4 chapter, when the commissioner has reasonable cause to believe that further pertinent
559.5 information may exist on the subject of the background study, the subject shall provide the
559.6 commissioner with a set of classifiable fingerprints obtained from an authorized agency.

559.7 (b) Before the implementation of NETStudy 2.0, for purposes of requiring fingerprints,
559.8 the commissioner has reasonable cause when, but not limited to, the:

559.9 (1) information from the Bureau of Criminal Apprehension indicates that the subject is
559.10 a multistate offender;

559.11 (2) information from the Bureau of Criminal Apprehension indicates that multistate
559.12 offender status is undetermined; or

559.13 (3) commissioner has received a report from the subject or a third party indicating that
559.14 the subject has a criminal history in a jurisdiction other than Minnesota.

559.15 (c) Notwithstanding paragraph (d), for background studies conducted by the commissioner
559.16 for child foster care, adoptions, or a transfer of permanent legal and physical custody of a
559.17 child, the subject of the background study, who is 18 years of age or older, shall provide
559.18 the commissioner with a set of classifiable fingerprints obtained from an authorized agency
559.19 for a national criminal history record check.

559.20 (d) For background studies initiated on or after the implementation of NETStudy 2.0,
559.21 every subject of a background study must provide the commissioner with a set of the
559.22 background study subject's classifiable fingerprints and photograph. The photograph and
559.23 fingerprints must be recorded at the same time by the commissioner's authorized fingerprint
559.24 collection vendor and sent to the commissioner through the commissioner's secure data
559.25 system described in section 245C.32, subdivision 1a, paragraph (b). The fingerprints shall
559.26 not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or
559.27 the commissioner, but will be retained by the Federal Bureau of Investigation. The
559.28 commissioner's authorized fingerprint collection vendor shall, for purposes of verifying the
559.29 identity of the background study subject, be able to view the identifying information entered
559.30 into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the
559.31 subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized
559.32 fingerprint collection vendor shall retain no more than the name and date and time the
559.33 subject's fingerprints were recorded and sent, only as necessary for auditing and billing
559.34 activities.

560.1 (e) When specifically required by law, fingerprints collected under this section must be
560.2 submitted for a national criminal history record check.

560.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

560.4 Sec. 18. Minnesota Statutes 2016, section 245C.05, subdivision 7, is amended to read:

560.5 Subd. 7. **Probation officer and corrections agent.** (a) A probation officer or corrections
560.6 agent shall notify the commissioner of an individual's conviction if the individual:

560.7 (1) has been affiliated with a program or facility regulated by the Department of Human
560.8 Services or Department of Health, a facility serving children or youth licensed by the
560.9 Department of Corrections, or any type of home care agency or provider of personal care
560.10 assistance services within the preceding year; and

560.11 (2) has been convicted of a crime constituting a disqualification under section 245C.14.

560.12 (b) For the purpose of this subdivision, "conviction" has the meaning given it in section
560.13 609.02, subdivision 5.

560.14 (c) The commissioner, in consultation with the commissioner of corrections, shall develop
560.15 forms and information necessary to implement this subdivision and shall provide the forms
560.16 and information to the commissioner of corrections for distribution to local probation officers
560.17 and corrections agents.

560.18 (d) The commissioner shall inform individuals subject to a background study that criminal
560.19 convictions for disqualifying crimes ~~will~~ shall be reported to the commissioner by the
560.20 corrections system.

560.21 (e) A probation officer, corrections agent, or corrections agency is not civilly or criminally
560.22 liable for disclosing or failing to disclose the information required by this subdivision.

560.23 (f) Upon receipt of disqualifying information, the commissioner shall provide the notice
560.24 required under section 245C.17, as appropriate, to agencies on record as having initiated a
560.25 background study or making a request for documentation of the background study status
560.26 of the individual.

560.27 (g) This subdivision does not apply to family child care programs or legal nonlicensed
560.28 child care programs for individuals whose background study was completed in NETStudy
560.29 2.0.

560.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

561.1 Sec. 19. Minnesota Statutes 2016, section 245C.08, subdivision 1, is amended to read:

561.2 Subdivision 1. **Background studies conducted by Department of Human Services.**

561.3 (a) For a background study conducted by the Department of Human Services, the
561.4 commissioner shall review:

561.5 (1) information related to names of substantiated perpetrators of maltreatment of
561.6 vulnerable adults that has been received by the commissioner as required under section
561.7 626.557, subdivision 9c, paragraph (j);

561.8 (2) the commissioner's records relating to the maltreatment of minors in licensed
561.9 programs, and from findings of maltreatment of minors as indicated through the social
561.10 service information system;

561.11 (3) information from juvenile courts as required in subdivision 4 for individuals listed
561.12 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

561.13 (4) information from the Bureau of Criminal Apprehension, including information
561.14 regarding a background study subject's registration in Minnesota as a predatory offender
561.15 under section 243.166;

561.16 (5) except as provided in clause (6), information ~~from the national crime information~~
561.17 ~~system~~ received as a result of submission of fingerprints for a national criminal history
561.18 record check, when the commissioner has reasonable cause as defined under section 245C.05,
561.19 subdivision 5, or as required under section 144.057, subdivision 1, clause (2); ~~and~~

561.20 (6) for a background study related to a child foster care application for licensure, a
561.21 transfer of permanent legal and physical custody of a child under sections 260C.503 to
561.22 260C.515, or adoptions, and for a background study required for family child care, certified
561.23 license-exempt child care, child care centers, and legal nonlicensed child care authorized
561.24 under chapter 119B, the commissioner shall also review:

561.25 (i) information from the child abuse and neglect registry for any state in which the
561.26 background study subject has resided for the past five years; and

561.27 (ii) ~~information from national crime information databases~~, when the background study
561.28 subject is 18 years of age or older-, information received following submission of fingerprints
561.29 for a national criminal history record check; and

561.30 (7) for a background study required for family child care, certified license-exempt child
561.31 care centers, licensed child care centers, and legal nonlicensed child care authorized under
561.32 chapter 119B. The background study shall also include a name and date-of-birth search of
561.33 the National Sex Offender Public Web site.

562.1 (b) Notwithstanding expungement by a court, the commissioner may consider information
562.2 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice
562.3 of the petition for expungement and the court order for expungement is directed specifically
562.4 to the commissioner.

562.5 (c) The commissioner shall also review criminal case information received according
562.6 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
562.7 to individuals who have already been studied under this chapter and who remain affiliated
562.8 with the agency that initiated the background study.

562.9 (d) When the commissioner has reasonable cause to believe that the identity of a
562.10 background study subject is uncertain, the commissioner may require the subject to provide
562.11 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
562.12 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph
562.13 shall not be saved by the commissioner after they have been used to verify the identity of
562.14 the background study subject against the particular criminal record in question.

562.15 (e) The commissioner may inform the entity that initiated a background study under
562.16 NETStudy 2.0 of the status of processing of the subject's fingerprints.

562.17 **EFFECTIVE DATE.** This section is effective October 1, 2017.

562.18 Sec. 20. Minnesota Statutes 2016, section 245C.08, subdivision 2, is amended to read:

562.19 Subd. 2. **Background studies conducted by a county agency for family child care.**

562.20 (a) Before the implementation of NETStudy 2.0, for a background study conducted by a
562.21 county agency for family child care services, the commissioner shall review:

562.22 (1) information from the county agency's record of substantiated maltreatment of adults
562.23 and the maltreatment of minors;

562.24 (2) information from juvenile courts as required in subdivision 4 for:

562.25 (i) individuals listed in section 245C.03, subdivision 1, paragraph (a), who are ages 13
562.26 through 23 living in the household where the licensed services will be provided; and

562.27 (ii) any other individual listed under section 245C.03, subdivision 1, when there is
562.28 reasonable cause; and

562.29 (3) information from the Bureau of Criminal Apprehension.

562.30 (b) If the individual has resided in the county for less than five years, the study shall
562.31 include the records specified under paragraph (a) for the previous county or counties of
562.32 residence for the past five years.

563.1 (c) Notwithstanding expungement by a court, the county agency may consider information
563.2 obtained under paragraph (a), clause (3), unless the commissioner received notice of the
563.3 petition for expungement and the court order for expungement is directed specifically to
563.4 the commissioner.

563.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

563.6 Sec. 21. Minnesota Statutes 2016, section 245C.08, subdivision 4, is amended to read:

563.7 Subd. 4. **Juvenile court records.** (a) For a background study conducted by the
563.8 Department of Human Services, the commissioner shall review records from the juvenile
563.9 courts for an individual studied under section 245C.03, subdivision 1, paragraph (a), when
563.10 the commissioner has reasonable cause.

563.11 (b) For a background study conducted by a county agency for family child care before
563.12 the implementation of NETStudy 2.0, the commissioner shall review records from the
563.13 juvenile courts for individuals listed in section 245C.03, subdivision 1, who are ages 13
563.14 through 23 living in the household where the licensed services will be provided. The
563.15 commissioner shall also review records from juvenile courts for any other individual listed
563.16 under section 245C.03, subdivision 1, when the commissioner has reasonable cause.

563.17 (c) The juvenile courts shall help with the study by giving the commissioner existing
563.18 juvenile court records relating to delinquency proceedings held on individuals described in
563.19 section 245C.03, subdivision 1, paragraph (a), when requested pursuant to this subdivision.

563.20 (d) For purposes of this chapter, a finding that a delinquency petition is proven in juvenile
563.21 court shall be considered a conviction in state district court.

563.22 (e) Juvenile courts shall provide orders of involuntary and voluntary termination of
563.23 parental rights under section 260C.301 to the commissioner upon request for purposes of
563.24 conducting a background study under this chapter.

563.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

563.26 Sec. 22. Minnesota Statutes 2016, section 245C.09, is amended by adding a subdivision
563.27 to read:

563.28 Subd. 3. **False statement in connection with a background study.** An individual shall
563.29 be disqualified for knowingly making a materially false statement in connection with a
563.30 background study.

563.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

564.1 Sec. 23. Minnesota Statutes 2016, section 245C.10, subdivision 9, is amended to read:

564.2 Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost
564.3 of background studies required under section 245C.03, subdivision 1, for all programs that
564.4 are licensed by the commissioner, except child foster care ~~and~~ for certified license-exempt
564.5 child care centers, licensed child care centers, and legal nonlicensed care authorized under
564.6 chapter 119B, and licensed family child care, through a fee of no more than \$20 per study
564.7 charged to the license holder. The fees collected under this subdivision are appropriated to
564.8 the commissioner for the purpose of conducting background studies.

564.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

564.10 Sec. 24. Minnesota Statutes 2016, section 245C.10, is amended by adding a subdivision
564.11 to read:

564.12 Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background
564.13 study required for family child care, certified license-exempt child care centers, licensed
564.14 child care centers, and legal nonlicensed child care providers authorized under chapter 119B
564.15 through a fee of no more than \$30 per study charged to the license holder. The fees collected
564.16 under this subdivision are appropriated to the commissioner to conduct background studies.

564.17 Sec. 25. Minnesota Statutes 2016, section 245C.11, subdivision 3, is amended to read:

564.18 Subd. 3. **Criminal history data.** County agencies shall have access to the criminal
564.19 history data in the same manner as county licensing agencies under this chapter for purposes
564.20 of background studies completed before the implementation of NETStudy 2.0 by county
564.21 agencies on legal nonlicensed child care providers to determine eligibility for child care
564.22 funds under chapter 119B.

564.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

564.24 Sec. 26. Minnesota Statutes 2016, section 245C.15, is amended to read:

564.25 **245C.15 DISQUALIFYING CRIMES OR CONDUCT.**

564.26 Subdivision 1. **Permanent disqualification.** (a) An individual is disqualified under
564.27 section 245C.14 if: (1) regardless of how much time has passed since the discharge of the
564.28 sentence imposed, if any, for the offense; and (2) unless otherwise specified, regardless of
564.29 the level of the offense, the individual has committed any of the following offenses: sections
564.30 243.166 (violation of predatory offender registration law); 609.185 (murder in the first
564.31 degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20

565.1 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); a felony
565.2 offense under 609.221 or 609.222 (assault in the first or second degree); a felony conviction
565.3 under section 609.223 or 609.2231 (assault in the third or fourth degree); a felony offense
565.4 under sections 609.2242 and 609.2243 (domestic assault), spousal abuse, child abuse or
565.5 neglect, or a crime against children; 609.2247 (domestic assault by strangulation); any
565.6 conviction under section 609.224 or 609.2242 (assault in the fifth degree or domestic assault)
565.7 for an offense committed by an adult against a child; 609.228 (great bodily harm caused by
565.8 distribution of drugs); 609.245 (aggravated robbery); 609.25 (kidnapping); 609.2661 (murder
565.9 of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second
565.10 degree); 609.2663 (murder of an unborn child in the third degree); 609.282 (labor trafficking);
565.11 609.322 (solicitation, inducement, and promotion of prostitution); 609.324, subdivision 1
565.12 (other prohibited acts); 609.342 (criminal sexual conduct in the first degree); 609.343
565.13 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the
565.14 third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal
565.15 sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.352
565.16 (solicitation of children to engage in sexual conduct); 609.365 (incest); a felony offense
565.17 under 609.377 (malicious punishment of a child); a felony offense under 609.378 (neglect
565.18 or endangerment of a child); 609.561 (arson in the first degree); a felony conviction under
565.19 section 609.562 or 609.563 (arson in the second or third degree); 609.66, subdivision 1e
565.20 (drive-by shooting); 609.746, subdivision 1, paragraph (e) (interference with privacy
565.21 involving a minor); 609.749, subdivision 3, 4, or 5 (felony-level stalking); 609.855,
565.22 subdivision 5 (shooting at or in a public transit vehicle or facility); 617.23, subdivision 2,
565.23 clause (1), or subdivision 3, clause (1) (indecent exposure involving a minor); 617.246 (use
565.24 of minors in sexual performance prohibited); or 617.247 (possession of pictorial
565.25 representations of minors); a felony-level conviction for a crime against a child or involving
565.26 child pornography. For a background study required for family child care, child care centers,
565.27 and legal nonlicensed child care authorized under chapter 119B, an individual is permanently
565.28 disqualified for a conviction at any level for child abuse or child neglect.

565.29 (b) An individual's aiding and abetting, attempt, or conspiracy to commit any of the
565.30 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes,
565.31 permanently disqualifies the individual under section 245C.14.

565.32 (c) An individual's offense in any other state or country, where the elements of the offense
565.33 are substantially similar to any of the offenses listed in paragraph (a), permanently disqualifies
565.34 the individual under section 245C.14.

566.1 (d) When a disqualification is based on a judicial determination other than a conviction,
566.2 the disqualification period begins from the date of the court order. When a disqualification
566.3 is based on an admission, the disqualification period begins from the date of an admission
566.4 in court. When a disqualification is based on an Alford Plea, the disqualification period
566.5 begins from the date the Alford Plea is entered in court. When a disqualification is based
566.6 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
566.7 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
566.8 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

566.9 (e) If the individual studied commits one of the offenses listed in paragraph (a) that is
566.10 specified as a felony-level only offense, but the sentence or level of offense is a gross
566.11 misdemeanor or misdemeanor, the individual is disqualified, but the disqualification
566.12 look-back period for the offense is the period applicable to gross misdemeanor or
566.13 misdemeanor offenses.

566.14 (f) An individual shall be disqualified as long as the individual is registered, or required
566.15 to be registered, on a state sex offender registry or repository or the National Sex Offender
566.16 Registry.

566.17 Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14
566.18 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any,
566.19 for the offense; and (2) the individual has committed a felony-level violation of any of the
566.20 following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182 (false
566.21 representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal Food
566.22 Stamp Program fraud); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113,
566.23 or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); a preponderance
566.24 of evidence of 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses
566.25 under 609.224 (assault in the fifth degree); 609.229 (crimes committed for benefit of a
566.26 gang); 609.2325 (criminal abuse of a vulnerable adult); 609.2335 (financial exploitation of
566.27 a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple
566.28 robbery); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the
566.29 first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267
566.30 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the
566.31 second degree); 609.268 (injury or death of an unborn child in the commission of a crime);
566.32 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical assistance fraud); 609.495
566.33 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree
566.34 tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.525
566.35 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen

567.1 property); 609.535 (issuance of dishonored checks); a preponderance of evidence of 609.562
567.2 (arson in the second degree); a preponderance of evidence of 609.563 (arson in the third
567.3 degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance
567.4 fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a
567.5 forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons);
567.6 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot);
567.7 609.713 (terroristic threats); 609.82 (fraud in obtaining credit); 609.821 (financial transaction
567.8 card fraud); 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241
567.9 (obscene materials and performances; distribution and exhibition prohibited; penalty);
567.10 624.713 (certain persons not to possess firearms); chapter 152 (drugs; controlled substance);
567.11 or Minnesota Statutes 2012, section 609.21; or a felony-level conviction involving alcohol
567.12 or drug use.

567.13 (b) An individual is disqualified under section 245C.14 if less than 15 years has passed
567.14 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
567.15 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

567.16 (c) An individual is disqualified under section 245C.14 if less than 15 years has passed
567.17 since the termination of the individual's parental rights under section 260C.301, subdivision
567.18 1, paragraph (b), or subdivision 3.

567.19 (d) An individual is disqualified under section 245C.14 if less than 15 years has passed
567.20 since the discharge of the sentence imposed for an offense in any other state or country, the
567.21 elements of which are substantially similar to the elements of the offenses listed in paragraph
567.22 (a).

567.23 (e) If the individual studied commits one of the offenses listed in paragraph (a), but the
567.24 sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is
567.25 disqualified but the disqualification look-back period for the offense is the period applicable
567.26 to the gross misdemeanor or misdemeanor disposition.

567.27 (f) When a disqualification is based on a judicial determination other than a conviction,
567.28 the disqualification period begins from the date of the court order. When a disqualification
567.29 is based on an admission, the disqualification period begins from the date of an admission
567.30 in court. When a disqualification is based on an Alford Plea, the disqualification period
567.31 begins from the date the Alford Plea is entered in court. When a disqualification is based
567.32 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
567.33 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
567.34 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

568.1 Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section
568.2 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed,
568.3 if any, for the offense; and (2) the individual has committed a gross misdemeanor-level
568.4 violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance);
568.5 268.182 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c)
568.6 (federal Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular
568.7 homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or
568.8 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree not by
568.9 an adult against a minor); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree
568.10 by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault not by
568.11 an adult against a minor); 609.23 (mistreatment of persons confined); 609.231 (mistreatment
568.12 of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal
568.13 neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);
568.14 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275
568.15 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in
568.16 prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378
568.17 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft);
568.18 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving
568.19 stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59
568.20 (possession of burglary tools); 609.611 (insurance fraud); 609.631 (check forgery; offering
568.21 a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly
568.22 conduct against a vulnerable adult); repeat gross-misdemeanor level offenses under 609.746
568.23 (interference with privacy); 609.749, subdivision 2 (stalking); 609.82 (fraud in obtaining
568.24 credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving
568.25 a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature,
568.26 distribution); 617.293 (harmful materials; dissemination and display to minors prohibited);
568.27 or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under
568.28 section 518B.01, subdivision 14.

568.29 (b) An individual is disqualified under section 245C.14 if less than ten years has passed
568.30 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
568.31 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

568.32 (c) An individual is disqualified under section 245C.14 if less than ten years has passed
568.33 since the discharge of the sentence imposed for an offense in any other state or country, the
568.34 elements of which are substantially similar to the elements of any of the offenses listed in
568.35 paragraph (a).

569.1 (d) If the individual studied commits one of the offenses listed in paragraph (a), but the
569.2 sentence or level of offense is a misdemeanor disposition, the individual is disqualified but
569.3 the disqualification lookback period for the offense is the period applicable to misdemeanors.

569.4 (e) When a disqualification is based on a judicial determination other than a conviction,
569.5 the disqualification period begins from the date of the court order. When a disqualification
569.6 is based on an admission, the disqualification period begins from the date of an admission
569.7 in court. When a disqualification is based on an Alford Plea, the disqualification period
569.8 begins from the date the Alford Plea is entered in court. When a disqualification is based
569.9 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
569.10 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
569.11 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

569.12 Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section
569.13 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed,
569.14 if any, for the offense; and (2) the individual has committed a misdemeanor-level violation
569.15 of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 268.182
569.16 (false representation; concealment of facts); 393.07, subdivision 10, paragraph (c) (federal
569.17 Food Stamp Program fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide
569.18 or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree);
569.19 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault
569.20 in the fifth degree not by an adult against a minor); 609.2242 (domestic assault not by an
569.21 adult against a minor); 609.2335 (financial exploitation of a vulnerable adult); 609.234
569.22 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child
569.23 in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232
569.24 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud);
569.25 609.52 (theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft);
569.26 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611
569.27 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference
569.28 with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or
569.29 package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial
569.30 transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful
569.31 materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012,
569.32 section 609.21; or violation of an order for protection under section 518B.01 (Domestic
569.33 Abuse Act).

569.34 (b) An individual is disqualified under section 245C.14 if less than seven years has
569.35 passed since a determination or disposition of the individual's:

570.1 (1) failure to make required reports under section 626.556, subdivision 3, or 626.557,
570.2 subdivision 3, for incidents in which: (i) the final disposition under section 626.556 or
570.3 626.557 was substantiated maltreatment, and (ii) the maltreatment was recurring or serious;
570.4 or

570.5 (2) substantiated serious or recurring maltreatment of a minor under section 626.556, a
570.6 vulnerable adult under section 626.557, or serious or recurring maltreatment in any other
570.7 state, the elements of which are substantially similar to the elements of maltreatment under
570.8 section 626.556 or 626.557 for which: (i) there is a preponderance of evidence that the
570.9 maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

570.10 (c) An individual is disqualified under section 245C.14 if less than seven years has
570.11 passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of
570.12 the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
570.13 Statutes.

570.14 (d) An individual is disqualified under section 245C.14 if less than seven years has
570.15 passed since the discharge of the sentence imposed for an offense in any other state or
570.16 country, the elements of which are substantially similar to the elements of any of the offenses
570.17 listed in paragraphs (a) and (b).

570.18 (e) When a disqualification is based on a judicial determination other than a conviction,
570.19 the disqualification period begins from the date of the court order. When a disqualification
570.20 is based on an admission, the disqualification period begins from the date of an admission
570.21 in court. When a disqualification is based on an Alford Plea, the disqualification period
570.22 begins from the date the Alford Plea is entered in court. When a disqualification is based
570.23 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
570.24 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
570.25 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

570.26 (f) An individual is disqualified under section 245C.14 if less than seven years has passed
570.27 since the individual was disqualified under section 256.98, subdivision 8.

570.28 Subd. 5. **Mental illness.** The commissioner may not disqualify an individual subject to
570.29 a background study under this chapter because that individual has, or has had, a mental
570.30 illness as defined in section 245.462, subdivision 20.

570.31 **EFFECTIVE DATE.** This section is effective October 1, 2017.

571.1 Sec. 27. Minnesota Statutes 2016, section 245C.16, subdivision 1, is amended to read:

571.2 Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines
571.3 that the individual studied has a disqualifying characteristic, the commissioner shall review
571.4 the information immediately available and make a determination as to the subject's immediate
571.5 risk of harm to persons served by the program where the individual studied will have direct
571.6 contact with, or access to, people receiving services.

571.7 (b) The commissioner shall consider all relevant information available, including the
571.8 following factors in determining the immediate risk of harm:

571.9 (1) the recency of the disqualifying characteristic;

571.10 (2) the recency of discharge from probation for the crimes;

571.11 (3) the number of disqualifying characteristics;

571.12 (4) the intrusiveness or violence of the disqualifying characteristic;

571.13 (5) the vulnerability of the victim involved in the disqualifying characteristic;

571.14 (6) the similarity of the victim to the persons served by the program where the individual
571.15 studied will have direct contact;

571.16 (7) whether the individual has a disqualification from a previous background study that
571.17 has not been set aside; and

571.18 (8) if the individual has a disqualification which may not be set aside because it is a
571.19 permanent bar under section 245C.24, subdivision 1, or the individual has a felony-level
571.20 conviction for a drug-related offense in the last five years, the commissioner may order the
571.21 immediate removal of the individual from any position allowing direct contact with, or
571.22 access to, persons receiving services from the program.

571.23 (c) This section does not apply when the subject of a background study is regulated by
571.24 a health-related licensing board as defined in chapter 214, and the subject is determined to
571.25 be responsible for substantiated maltreatment under section 626.556 or 626.557.

571.26 (d) This section does not apply to a background study related to an initial application
571.27 for a child foster care license.

571.28 (e) Except for paragraph (f), this section does not apply to a background study that is
571.29 also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a
571.30 personal care assistant or a qualified professional as defined in section 256B.0659,
571.31 subdivision 1.

572.1 (f) If the commissioner has reason to believe, based on arrest information or an active
572.2 maltreatment investigation, that an individual poses an imminent risk of harm to persons
572.3 receiving services, the commissioner may order that the person be continuously supervised
572.4 or immediately removed pending the conclusion of the maltreatment investigation or criminal
572.5 proceedings.

572.6 **EFFECTIVE DATE.** This section is effective October 1, 2017.

572.7 Sec. 28. Minnesota Statutes 2016, section 245C.17, subdivision 6, is amended to read:

572.8 Subd. 6. **Notice to county agency.** For studies on individuals related to a license to
572.9 provide adult foster care and family adult day services and, effective upon implementation
572.10 of NETStudy 2.0, family child care and legal nonlicensed child care authorized under chapter
572.11 119B, the commissioner shall also provide a notice of the background study results to the
572.12 county agency that initiated the background study.

572.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

572.14 Sec. 29. Minnesota Statutes 2016, section 245C.21, subdivision 1, is amended to read:

572.15 Subdivision 1. **Who may request reconsideration.** An individual who is the subject of
572.16 a disqualification may request a reconsideration of the disqualification pursuant to this
572.17 section. The individual must submit the request for reconsideration to the commissioner in
572.18 writing.

572.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

572.20 Sec. 30. Minnesota Statutes 2016, section 245C.22, subdivision 5, is amended to read:

572.21 Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under
572.22 this section, the disqualified individual remains disqualified, but may hold a license and
572.23 have direct contact with or access to persons receiving services. Except as provided in
572.24 paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the
572.25 licensed program, applicant, or agency specified in the set aside notice under section 245C.23.
572.26 For personal care provider organizations, the commissioner's set-aside may further be limited
572.27 to a specific individual who is receiving services. For new background studies required
572.28 under section 245C.04, subdivision 1, paragraph ~~(g)~~ (h), if an individual's disqualification
572.29 was previously set aside for the license holder's program and the new background study
572.30 results in no new information that indicates the individual may pose a risk of harm to persons
572.31 receiving services from the license holder, the previous set-aside shall remain in effect.

573.1 (b) If the commissioner has previously set aside an individual's disqualification for one
573.2 or more programs or agencies, and the individual is the subject of a subsequent background
573.3 study for a different program or agency, the commissioner shall determine whether the
573.4 disqualification is set aside for the program or agency that initiated the subsequent
573.5 background study. A notice of a set-aside under paragraph (c) shall be issued within 15
573.6 working days if all of the following criteria are met:

573.7 (1) the subsequent background study was initiated in connection with a program licensed
573.8 or regulated under the same provisions of law and rule for at least one program for which
573.9 the individual's disqualification was previously set aside by the commissioner;

573.10 (2) the individual is not disqualified for an offense specified in section 245C.15,
573.11 subdivision 1 or 2;

573.12 (3) the commissioner has received no new information to indicate that the individual
573.13 may pose a risk of harm to any person served by the program; and

573.14 (4) the previous set-aside was not limited to a specific person receiving services.

573.15 (c) When a disqualification is set aside under paragraph (b), the notice of background
573.16 study results issued under section 245C.17, in addition to the requirements under section
573.17 245C.17, shall state that the disqualification is set aside for the program or agency that
573.18 initiated the subsequent background study. The notice must inform the individual that the
573.19 individual may request reconsideration of the disqualification under section 245C.21 on the
573.20 basis that the information used to disqualify the individual is incorrect.

573.21 **EFFECTIVE DATE.** This section is effective October 1, 2017.

573.22 Sec. 31. Minnesota Statutes 2016, section 245C.22, subdivision 7, is amended to read:

573.23 Subd. 7. **Classification of certain data.** (a) Notwithstanding section 13.46, except as
573.24 provided in paragraph (f), upon setting aside a disqualification under this section, the identity
573.25 of the disqualified individual who received the set-aside and the individual's disqualifying
573.26 characteristics are public data if the set-aside was:

573.27 (1) for any disqualifying characteristic under section 245C.15, except a felony-level
573.28 conviction for a drug-related offense within the past five years, when the set-aside relates
573.29 to a child care center or a family child care provider licensed under chapter 245A, certified
573.30 license-exempt child care center, or legal nonlicensed family child care center; or

573.31 (2) for a disqualifying characteristic under section 245C.15, subdivision 2.

574.1 (b) Notwithstanding section 13.46, upon granting a variance to a license holder under
574.2 section 245C.30, the identity of the disqualified individual who is the subject of the variance,
574.3 the individual's disqualifying characteristics under section 245C.15, and the terms of the
574.4 variance are public data, except as provided in paragraph (c), clause (6), when the variance:

574.5 (1) is issued to a child care center or a family child care provider licensed under chapter
574.6 245A; or

574.7 (2) relates to an individual with a disqualifying characteristic under section 245C.15,
574.8 subdivision 2.

574.9 (c) The identity of a disqualified individual and the reason for disqualification remain
574.10 private data when:

574.11 (1) a disqualification is not set aside and no variance is granted, except as provided under
574.12 section 13.46, subdivision 4;

574.13 (2) the data are not public under paragraph (a) or (b);

574.14 (3) the disqualification is rescinded because the information relied upon to disqualify
574.15 the individual is incorrect;

574.16 (4) the disqualification relates to a license to provide relative child foster care. As used
574.17 in this clause, "relative" has the meaning given it under section 260C.007, subdivision 26b
574.18 or 27; ~~or~~

574.19 (5) the disqualified individual is a household member of a licensed foster care provider
574.20 and:

574.21 (i) the disqualified individual previously received foster care services from this licensed
574.22 foster care provider;

574.23 (ii) the disqualified individual was subsequently adopted by this licensed foster care
574.24 provider; and

574.25 (iii) the disqualifying act occurred before the adoption; or

574.26 (6) a variance is granted to a child care center or family child care license holder for an
574.27 individual's disqualification that is based on a felony-level conviction for a drug-related
574.28 offense that occurred within the past five years.

574.29 (d) Licensed family child care providers and child care centers must provide notices as
574.30 required under section 245C.301.

575.1 (e) Notwithstanding paragraphs (a) and (b), the identity of household members who are
575.2 the subject of a disqualification related set-aside or variance is not public data if:

575.3 (1) the household member resides in the residence where the family child care is provided;

575.4 (2) the subject of the set-aside or variance is under the age of 18 years; and

575.5 (3) the set-aside or variance only relates to a disqualification under section 245C.15,
575.6 subdivision 4, for a misdemeanor-level theft crime as defined in section 609.52.

575.7 (f) When the commissioner has reason to know that a disqualified individual has received
575.8 an order for expungement for the disqualifying record that does not limit the commissioner's
575.9 access to the record, and the record was opened or exchanged with the commissioner for
575.10 purposes of a background study under this chapter, the data that would otherwise become
575.11 public under paragraph (a) or (b) remain private data.

575.12 **EFFECTIVE DATE.** This section is effective October 1, 2017.

575.13 Sec. 32. Minnesota Statutes 2016, section 245C.23, is amended to read:

575.14 **245C.23 COMMISSIONER'S RECONSIDERATION NOTICE.**

575.15 Subdivision 1. **Disqualification that is rescinded or set aside.** (a) If the commissioner
575.16 rescinds or sets aside a disqualification, the commissioner shall notify the applicant, license
575.17 holder, or other entity in writing or by electronic transmission of the decision.

575.18 (b) In the notice from the commissioner that a disqualification has been rescinded, the
575.19 commissioner must inform the applicant, license holder, or other entity that the information
575.20 relied upon to disqualify the individual was incorrect.

575.21 (c) Except as provided in ~~paragraph~~ paragraphs (d) and (e), in the notice from the
575.22 commissioner that a disqualification has been set aside, the commissioner must inform the
575.23 applicant, license holder, or other entity of the reason for the individual's disqualification
575.24 and that information about which factors under section 245C.22, subdivision 4, were the
575.25 basis of the decision to set aside the disqualification are available to the license holder upon
575.26 request without the consent of the background study subject.

575.27 (d) When the commissioner has reason to know that a disqualified individual has received
575.28 an order for expungement for the disqualifying record that does not limit the commissioner's
575.29 access to the record, and the record was opened or exchanged with the commissioner for
575.30 purposes of a background study under this chapter, the information provided under paragraph
575.31 (c) must only inform the applicant, license holder, or other entity that the disqualifying
575.32 criminal record is sealed under a court order.

576.1 (e) The notification requirements in paragraph (c) do not apply when the set aside is
576.2 granted to an individual related to a background study for a licensed child care center,
576.3 certified license-exempt child care center, or family child care license holder, or for a legal
576.4 nonlicensed child care provider authorized under chapter 119B, and the individual is
576.5 disqualified for a felony-level conviction for a drug-related offense that occurred within the
576.6 past five years. The notice that the individual's disqualification is set aside must inform the
576.7 applicant, license holder, or legal nonlicensed child care provider that the disqualifying
576.8 criminal record is not public.

576.9 **Subd. 2. Commissioner's notice of disqualification that is not set aside.** (a) The
576.10 commissioner shall notify the license holder of the disqualification and order the license
576.11 holder to immediately remove the individual from any position allowing direct contact with
576.12 persons receiving services from the license holder if:

576.13 (1) the individual studied does not submit a timely request for reconsideration under
576.14 section 245C.21;

576.15 (2) the individual submits a timely request for reconsideration, but the commissioner
576.16 does not set aside the disqualification for that license holder under section 245C.22, unless
576.17 the individual has a right to request a hearing under section 245C.27, 245C.28, or 256.045;

576.18 (3) an individual who has a right to request a hearing under sections 245C.27 and 256.045,
576.19 or 245C.28 and chapter 14 for a disqualification that has not been set aside, does not request
576.20 a hearing within the specified time; or

576.21 (4) an individual submitted a timely request for a hearing under sections 245C.27 and
576.22 256.045, or 245C.28 and chapter 14, but the commissioner does not set aside the
576.23 disqualification under section 245A.08, subdivision 5, or 256.045.

576.24 (b) If the commissioner does not set aside the disqualification under section 245C.22,
576.25 and the license holder was previously ordered under section 245C.17 to immediately remove
576.26 the disqualified individual from direct contact with persons receiving services or to ensure
576.27 that the individual is under continuous, direct supervision when providing direct contact
576.28 services, the order remains in effect pending the outcome of a hearing under sections 245C.27
576.29 and 256.045, or 245C.28 and chapter 14.

576.30 (c) If the commissioner does not set aside the disqualification under section 245C.22,
576.31 and the license holder was not previously ordered under section 245C.17 to immediately
576.32 remove the disqualified individual from direct contact with persons receiving services or
576.33 to ensure that the individual is under continuous direct supervision when providing direct
576.34 contact services, the commissioner shall order the individual to remain under continuous

577.1 direct supervision pending the outcome of a hearing under sections 245C.27 and 256.045,
577.2 or 245C.28 and chapter 14.

577.3 (d) For background studies related to child foster care, the commissioner shall also notify
577.4 the county or private agency that initiated the study of the results of the reconsideration.

577.5 (e) For background studies related to family child care, legal nonlicensed child care,
577.6 adult foster care, and family adult day services, the commissioner shall also notify the county
577.7 that initiated the study of the results of the reconsideration.

577.8 **EFFECTIVE DATE.** This section is effective October 1, 2017.

577.9 Sec. 33. Minnesota Statutes 2016, section 245C.24, subdivision 3, is amended to read:

577.10 Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set
577.11 aside the disqualification of an individual in connection with a license to provide family
577.12 child care for children, foster care for children in the provider's home, or foster care or day
577.13 care services for adults in the provider's home if: (1) less than ten years has passed since
577.14 the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based
577.15 on a preponderance of evidence determination under section 245C.14, subdivision 1,
577.16 paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph
577.17 (a), clause (1), and less than ten years has passed since the individual committed the act or
577.18 admitted to committing the act, whichever is later; and (3) the individual has committed a
577.19 violation of any of the following offenses: sections 609.165 (felon ineligible to possess
577.20 firearm); criminal vehicular homicide or criminal vehicular operation causing death under
577.21 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding
577.22 suicide or aiding attempted suicide); preponderance of evidence of felony violations under
577.23 609.223 or 609.2231 (assault in the third or fourth degree); 609.229 (crimes committed for
577.24 benefit of a gang); 609.713 (terroristic threats); 609.235 (use of drugs to injure or to facilitate
577.25 crime); 609.24 (simple robbery); 609.255 (false imprisonment); 609.562 (arson in the second
577.26 degree); 609.71 (riot); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree
577.27 tampering with a witness); burglary in the first or second degree under 609.582 (burglary);
577.28 609.66 (dangerous weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled
577.29 shotguns); 609.749, subdivision 2 (gross misdemeanor stalking); 152.021 or 152.022
577.30 (controlled substance crime in the first or second degree); 152.023, subdivision 1, clause
577.31 (3) or (4) or subdivision 2, clause (4) (controlled substance crime in the third degree);
577.32 152.024, subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth
577.33 degree); 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against
577.34 a vulnerable adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of

578.1 residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal
 578.2 neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);
 578.3 609.234 (failure to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of
 578.4 an unborn child in the first or second degree); 609.267 to 609.2672 (assault of an unborn
 578.5 child in the first, second, or third degree); 609.268 (injury or death of an unborn child in
 578.6 the commission of a crime); repeat offenses under 617.23 (indecent exposure); 617.293
 578.7 (disseminating or displaying harmful material to minors); a felony-level conviction involving
 578.8 alcohol or drug use, a gross misdemeanor offense under 609.324, subdivision 1 (other
 578.9 prohibited acts); a gross misdemeanor offense under 609.378 (neglect or endangerment of
 578.10 a child); a gross misdemeanor offense under 609.377 (malicious punishment of a child);
 578.11 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain
 578.12 persons not to possess firearms); or Minnesota Statutes 2012, section 609.21.

578.13 (b) The commissioner may not set aside the disqualification of an individual if less than
 578.14 ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to
 578.15 commit any of the offenses listed in paragraph (a) as each of these offenses is defined in
 578.16 Minnesota Statutes.

578.17 (c) The commissioner may not set aside the disqualification of an individual if less than
 578.18 ten years have passed since the discharge of the sentence imposed for an offense in any
 578.19 other state or country, the elements of which are substantially similar to the elements of any
 578.20 of the offenses listed in paragraph (a).

578.21 **EFFECTIVE DATE.** This section is effective October 1, 2017.

578.22 Sec. 34. Minnesota Statutes 2016, section 245C.25, is amended to read:

578.23 **245C.25 CONSOLIDATED RECONSIDERATION OF MALTREATMENT**
 578.24 **DETERMINATION AND DISQUALIFICATION.**

578.25 ~~(a)~~ If an individual is disqualified on the basis of a determination of maltreatment under
 578.26 section 626.556 or 626.557, which was serious or recurring, and the individual requests
 578.27 reconsideration of the maltreatment determination under section 626.556, subdivision 10i,
 578.28 or 626.557, subdivision 9d, and also requests reconsideration of the disqualification under
 578.29 section 245C.21, the commissioner shall consolidate the reconsideration of the maltreatment
 578.30 determination and the disqualification into a single reconsideration.

578.31 ~~(b) For maltreatment and disqualification determinations made by county agencies, the~~
 578.32 ~~county agency shall conduct the consolidated reconsideration. If the county agency has~~
 578.33 ~~disqualified an individual on multiple bases, one of which is a county maltreatment~~

579.1 ~~determination for which the individual has a right to request reconsideration, the county~~
 579.2 ~~shall conduct the reconsideration of all disqualifications.~~

579.3 ~~(c) If the county has previously conducted a consolidated reconsideration under paragraph~~
 579.4 ~~(b) of a maltreatment determination and a disqualification based on serious or recurring~~
 579.5 ~~maltreatment, and the county subsequently disqualifies the individual based on that~~
 579.6 ~~determination, the county shall conduct the reconsideration of the subsequent disqualification.~~
 579.7 ~~The scope of the subsequent disqualification shall be limited to whether the individual poses~~
 579.8 ~~a risk of harm in accordance with section 245C.22, subdivision 4. If the commissioner~~
 579.9 ~~subsequently disqualifies the individual in connection with a child foster care license based~~
 579.10 ~~on the county's previous maltreatment determination, the commissioner shall conduct the~~
 579.11 ~~reconsideration of the subsequent disqualification.~~

579.12 **EFFECTIVE DATE.** This section is effective October 1, 2017.

579.13 Sec. 35. Minnesota Statutes 2016, section 245C.30, subdivision 2, is amended to read:

579.14 Subd. 2. **Disclosure of reason for disqualification.** (a) The commissioner may not grant
 579.15 a variance for a disqualified individual unless the applicant or license holder requests the
 579.16 variance and the disqualified individual provides written consent for the commissioner to
 579.17 disclose to the applicant or license holder the reason for the disqualification.

579.18 (b) This subdivision does not apply to programs licensed to provide family child care
 579.19 for children, foster care for children in the provider's own home, or foster care or day care
 579.20 services for adults in the provider's own home. When the commissioner grants a variance
 579.21 for a disqualified individual in connection with a license to provide the services specified
 579.22 in this paragraph, the disqualified individual's consent is not required to disclose the reason
 579.23 for the disqualification to the license holder in the variance issued under subdivision 1,
 579.24 provided that the commissioner may not disclose the reason for the disqualification if the
 579.25 disqualification is based on a felony-level conviction for a drug-related offense within the
 579.26 past five years.

579.27 **EFFECTIVE DATE.** This section is effective October 1, 2017.

579.28 Sec. 36. **[245G.01] DEFINITIONS.**

579.29 Subdivision 1. Scope. The terms used in this chapter have the meanings given in this
 579.30 section.

580.1 Subd. 2. **Applicant.** "Applicant" means an individual or organization that is subject to
580.2 certification under this chapter and that applied for but is not yet granted certification under
580.3 this chapter.

580.4 Subd. 3. **Center operator or program operator.** "Center operator" or "program operator"
580.5 means the person exercising supervision or control over the center's or program's operations,
580.6 planning, and functioning. There may be more than one designated center operator or
580.7 program operator.

580.8 Subd. 4. **Certification holder.** "Certification holder" means the individual or organization
580.9 that is legally responsible for the operation of the center, and granted certification by the
580.10 commissioner under this chapter.

580.11 Subd. 5. **Certified license-exempt child care center.** "Certified license-exempt child
580.12 care center" means the commissioner's written authorization for a child care center excluded
580.13 from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), (11) to (13),
580.14 (15), (18), or (26), to register to receive child care assistance payments under chapter 119B.

580.15 Subd. 6. **Disinfecting.** "Disinfecting" means the use of a product capable of destroying
580.16 or inactivating harmful germs, except bacterial spores, consistent with label directions on
580.17 environmental surfaces including bathroom toilets and floors, diaper-changing surfaces,
580.18 and surfaces exposed to blood or other bodily fluids.

580.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

580.20 Sec. 37. **[245G.02] WHO MUST BE CERTIFIED.**

580.21 A program that is exempt from licensure under section 245A.03, subdivision 2, paragraph
580.22 (a), clause (5), (11) to (13), (15), (18), or (26), and is authorized to receive child care
580.23 assistance payments under chapter 119B, must be a certified license-exempt child care
580.24 center according to this section.

580.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

580.26 Sec. 38. **[245G.03] APPLICATION PROCEDURES.**

580.27 Subdivision 1. **Schedule.** The certification of license-exempt child care centers shall be
580.28 implemented by September 30, 2017. Certification applications shall be received and
580.29 processed on a phased-in schedule as determined by the commissioner.

580.30 Subd. 2. **Application submission.** The commissioner shall provide application
580.31 instructions and information about the rules and requirements of other state agencies that

581.1 affect the applicant. The certification application must be submitted in a manner prescribed
581.2 by the commissioner. The commissioner shall act on the application within 90 working days
581.3 of receiving a completed application.

581.4 Subd. 3. **Incomplete applications.** When the commissioner receives an application for
581.5 initial certification that is incomplete because the applicant failed to submit required
581.6 documents or is deficient because the documents submitted do not meet certification
581.7 requirements, the commissioner shall provide the applicant written notice that the application
581.8 is incomplete or deficient. In the notice, the commissioner shall identify documents that are
581.9 missing or deficient and give the applicant 45 days to resubmit a second application that is
581.10 complete. An applicant's failure to submit a complete application after receiving notice from
581.11 the commissioner is basis for certification denial.

581.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

581.13 Sec. 39. **[245G.04] COMMISSIONER'S RIGHT OF ACCESS.**

581.14 (a) When the commissioner is exercising the powers conferred by this chapter, whenever
581.15 the center is in operation and the information is relevant to the commissioner's inspection
581.16 or investigation, the commissioner must be given access to:

581.17 (1) the physical facility and grounds where the program is provided;

581.18 (2) documentation and records, including electronically maintained records;

581.19 (3) children served by the center; and

581.20 (4) staff and personnel records of current and former staff.

581.21 (b) The commissioner must be given access without prior notice and as often as the
581.22 commissioner considers necessary if the commissioner is investigating alleged maltreatment
581.23 or a violation of a law or rule, or conducting an inspection. When conducting an inspection,
581.24 the commissioner may request and shall receive assistance from other state, county, and
581.25 municipal governmental agencies and departments. The applicant or certification holder
581.26 shall allow the commissioner, at the commissioner's expense, to photocopy, photograph,
581.27 and make audio and video recordings during an inspection at the commissioner's expense.

581.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

582.1 Sec. 40. **[245G.05] MONITORING AND INSPECTIONS.**

582.2 (a) The commissioner must conduct an on-site inspection of a certified license-exempt
582.3 child care center at least annually to determine compliance with the health, safety, and fire
582.4 standards specific to a certified license-exempt child care center.

582.5 (b) No later than November 19, 2017, the commissioner shall make publicly available
582.6 on the department's Web site the results of inspection reports for all certified centers including
582.7 the number of deaths, serious injuries, and instances of substantiated child maltreatment
582.8 that occurred in certified centers each year.

582.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

582.10 Sec. 41. **[245G.06] CORRECTION ORDER.**

582.11 Subdivision 1. **Correction order requirements.** If the applicant or certification holder
582.12 failed to comply with a law or rule, the commissioner may issue a correction order. The
582.13 correction order must state:

582.14 (1) the condition that constitutes a violation of the law or rule;

582.15 (2) the specific law or rule violated; and

582.16 (3) the time allowed to correct each violation.

582.17 Subd. 2. **Reconsideration request.** (a) If the applicant or certification holder believes
582.18 that the commissioner's correction order is erroneous, the applicant or certification holder
582.19 may ask the commissioner to reconsider the part of the correction order that is allegedly
582.20 erroneous. A request for reconsideration must be made in writing, postmarked, and sent to
582.21 the commissioner within 20 calendar days after the applicant or certification holder received
582.22 the correction order, and must:

582.23 (1) specify the part of the correction order that is allegedly erroneous;

582.24 (2) explain why the specified part is erroneous; and

582.25 (3) include documentation to support the allegation of error.

582.26 (b) A request for reconsideration does not stay any provision or requirement of the
582.27 correction order. The commissioner's disposition of a request for reconsideration is final
582.28 and not subject to appeal.

582.29 Subd. 3. **Decertification following a correction order.** (a) If the commissioner finds
582.30 that the applicant or certification holder failed to correct the violation specified in the

583.1 correction order, the commissioner may decertify the license-exempt center pursuant to
583.2 section 245G.07.

583.3 (b) Nothing in this section prohibits the commissioner from decertifying a center
583.4 according to section 245G.07.

583.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

583.6 Sec. 42. **[245G.07] DECERTIFICATION.**

583.7 (a) The commissioner may decertify a center if a certification holder:

583.8 (1) failed to comply with an applicable law or rule; or

583.9 (2) knowingly withheld relevant information from or gave false or misleading information
583.10 to the commissioner in connection with an application for certification, in connection with
583.11 the background study status of an individual, during an investigation, or regarding compliance
583.12 with applicable laws or rules.

583.13 (b) When considering decertification, the commissioner shall consider the nature,
583.14 chronicity, or severity of the violation of law or rule.

583.15 (c) When a center is decertified, the center is ineligible to receive a child care assistance
583.16 payment.

583.17 **EFFECTIVE DATE.** This section is effective the day following final enactment.

583.18 Sec. 43. **[245G.08] STAFFING REQUIREMENTS.**

583.19 Subdivision 1. **Staffing requirements.** During hours of operation, a certified center
583.20 must have a director or designee on site who is responsible for overseeing implementation
583.21 of written policies relating to the management and control of the daily activities of the
583.22 program, ensuring the health and safety of program participants, and supervising staff and
583.23 volunteers.

583.24 Subd. 2. **Director qualifications.** The director must be 18 years of age or older and have
583.25 completed at least 16 hours of training in any of the following topic areas: child development
583.26 and learning; developmentally appropriate learning experiences; relationships with families;
583.27 assessment, evaluation, and individualization; historical and contemporary development of
583.28 early childhood education; professionalism; and health, safety, and nutrition.

583.29 Subd. 3. **Staff qualifications.** A staff person must be 16 years of age or older before
583.30 providing direct, unsupervised care to a child.

584.1 Subd. 4. **Maximum group size.** (a) For a child six weeks old through 16 months old,
 584.2 the maximum group size shall be no more than eight children.

584.3 (b) For a child 16 months old through 33 months old, the maximum group size shall be
 584.4 no more than 14 children.

584.5 (c) For a child 33 months old through prekindergarten, a maximum group size shall be
 584.6 no more than 20 children.

584.7 (d) For a child in kindergarten through 13 years old, a maximum group size shall be no
 584.8 more than 30 children.

584.9 (e) The maximum group size applies at all times except during group activity coordination
 584.10 time not exceeding 15 minutes, during a meal, outdoor activity, field trip, nap and rest, and
 584.11 special activity including a film, guest speaker, indoor large muscle activity, or holiday
 584.12 program.

584.13 Subd. 5. **Ratios.** (a) The minimally acceptable staff-to-child ratios are:

584.14 six weeks old through 16 months old 1:4

584.15 16 months old through 33 months old 1:7

584.16 33 months old through prekindergarten 1:10

584.17 kindergarten through 13 years old 1:15

584.18 (b) Kindergarten includes a child of sufficient age to have attended the first day of
 584.19 kindergarten or who is eligible to enter kindergarten within the next four months.

584.20 (c) For mixed groups, the ratio for the age group of the youngest child applies.

584.21 **EFFECTIVE DATE.** This section is effective the day following final enactment.

584.22 Sec. 44. **[245G.10] BACKGROUND STUDIES.**

584.23 Subdivision 1. **Documentation.** (a) The applicant or certification holder must submit
 584.24 and maintain documentation of a completed background study for:

584.25 (1) each person applying for the certification;

584.26 (2) each person identified as a center operator or program operator as defined in section
 584.27 245G.01, subdivision 5;

584.28 (3) each current or prospective staff person or contractor of the certified center who will
 584.29 have direct contact with a child served by the center;

585.1 (4) each volunteer who has direct contact with a child served by the center if the contact
585.2 is not under the continuous, direct supervision by an individual listed in clause (1), (2), or
585.3 (3); and

585.4 (5) each managerial staff of the certification holder with oversight and supervision of
585.5 the certified center.

585.6 (b) To be accepted for certification, a background study on every individual in subdivision
585.7 1, clause (1), must be completed under chapter 245C and result in a not disqualified
585.8 determination under section 245C.14 or a disqualification that was set aside under section
585.9 245C.22.

585.10 Subd. 2. **Direct contact.** (a) The subject of the background study may not provide direct
585.11 contact services to a child served by a certified center unless the subject is under continuous
585.12 direct supervision pending completion of the background study.

585.13 (b) The certified center must document in the staff person's personnel file the date the
585.14 program initiates a background study and the date the subject of the study first had direct
585.15 contact with a child served by the center.

585.16 **EFFECTIVE DATE.** This section is effective August 1, 2017.

585.17 Sec. 45. **[245G.11] REPORTING.**

585.18 (a) The certification holder must comply with the reporting requirements for abuse and
585.19 neglect specified in section 626.556. A person mandated to report physical or sexual child
585.20 abuse or neglect occurring within a certified center shall report the information to the
585.21 commissioner.

585.22 (b) The certification holder must inform the commissioner within 24 hours of:

585.23 (1) the death of a child in the program; and

585.24 (2) any injury to a child in the program that required treatment by a physician.

585.25 **EFFECTIVE DATE.** This section is effective August 1, 2017.

585.26 Sec. 46. **[245G.12] FEES.**

585.27 The commissioner shall consult with stakeholders to develop an administrative fee to
585.28 implement this chapter. By February 15, 2019, the commissioner shall provide
585.29 recommendations on the amount of an administrative fee to the legislative committees with
585.30 jurisdiction over health and human services policy and finance.

586.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

586.2 Sec. 47. **[245G.13] HEALTH AND SAFETY REQUIREMENTS.**

586.3 Subdivision 1. **Exclusion of sick children and infectious disease outbreak control.**

586.4 (a) A certified center must supervise and isolate a child from other children in the program
586.5 when a child becomes sick and immediately notify the sick child's parent or legal guardian.

586.6 (b) A certified center must post or give notice to the parent or legal guardian of an
586.7 exposed child the same day the program is notified of a child's contagious reportable disease
586.8 specified in Minnesota Rules, part 4605.7040, or scabies, impetigo, ringworm, or chicken
586.9 pox.

586.10 Subd. 2. **Immunizations.** By a child's date of attendance, the certified center must
586.11 maintain or have access to a record detailing the child's current immunizations or applicable
586.12 exemption.

586.13 Subd. 3. **Administration of medication.** (a) A certified center that chooses to administer
586.14 medicine must meet the requirements in this subdivision.

586.15 (b) The certified center must obtain written permission from the child's parent or legal
586.16 guardian before administering prescription medicine, diapering product, sunscreen lotion,
586.17 and insect repellent.

586.18 (c) The certified center must administer nonprescription medicine, diapering product,
586.19 sunscreen lotion, and insect repellent according to the manufacturer's instructions unless
586.20 provided written instructions by a licensed health professional to use a product differently.

586.21 (d) The certified center must obtain and follow written instructions from the prescribing
586.22 health professional before administering prescription medicine. Medicine with the child's
586.23 first and last name and current prescription information on the label is considered written
586.24 instructions.

586.25 (e) The certified center must ensure all medicine is:

586.26 (1) kept in the medicine's original container with a legible label stating the child's first
586.27 and last name;

586.28 (2) given only to the child whose name is on the label;

586.29 (3) not given after an expiration date on the label; and

586.30 (4) returned to the child's parent or legal guardian or destroyed, if unused.

587.1 (f) The certified center must document in the child's record the administration of
587.2 medication, including the child's first and last name; the name of the medication or
587.3 prescription number; the date, time, and dosage; and the name and signature of the person
587.4 who administered the medicine. This documentation must be available to the child's parent
587.5 or legal guardian.

587.6 (g) The certified center must store medicines, insect repellents, and diapering products
587.7 according to directions on the original container.

587.8 **Subd. 4. Preventing and responding to allergies.** (a) Before admitting a child for care,
587.9 the certified center must obtain documentation of any known allergies from the child's parent
587.10 or legal guardian. The certified center must maintain current allergy information in each
587.11 child's record. The allergy information must include:

587.12 (1) a description of the allergy, specific triggers, avoidance techniques, and symptoms
587.13 of an allergic reaction; and

587.14 (2) procedures for responding to an allergic reaction, including medication, dosages,
587.15 and a doctor's contact information.

587.16 (b) The certified center must inform staff of each child's current allergy information. At
587.17 least annually and when a change is made to allergy-related information in a child's record,
587.18 the certified center must inform staff of any change. Documentation that staff were informed
587.19 of the child's current allergy information must be kept on site.

587.20 (c) A child's allergy information must be available at all times including on site, when
587.21 on field trips, or during transportation. Food allergy information must be readily available
587.22 to staff in the area where food is prepared and served to the child.

587.23 **Subd. 5. Building and physical premises; free of hazards.** (a) The certified center
587.24 must document compliance with the State Fire Code by providing documentation of a fire
587.25 marshal inspection completed within the previous three years by a state fire marshal or a
587.26 local fire code inspector trained by the state fire marshal.

587.27 (b) The certified center must designate a primary indoor and outdoor space used for
587.28 child care on a facility site floor plan.

587.29 (c) The certified center must ensure the areas used by a child are clean and in good repair,
587.30 with structurally sound and functional furniture and equipment that is appropriate to the
587.31 age and size of a child who uses the area.

588.1 (d) The certified center must ensure hazardous items including but not limited to sharp
588.2 objects, medicines, cleaning supplies, poisonous plants, and chemicals are out of reach of
588.3 a child.

588.4 (e) The certified center must safely handle and dispose of bodily fluids and other
588.5 potentially infectious fluids by using gloves, disinfecting surfaces that come in contact with
588.6 potentially infectious bodily fluids, and disposing of bodily fluid in a securely sealed plastic
588.7 bag.

588.8 Subd. 6. **Transporting children.** (a) If a certified center chooses to transport a child,
588.9 the certified center must ensure that the driver of the vehicle holds a valid driver's license,
588.10 appropriate to the vehicle driven.

588.11 (b) If a certified center chooses to transport a child, the center must comply with all seat
588.12 belt and child passenger restraint system requirements under sections 169.685 and 169.686.

588.13 **EFFECTIVE DATE.** This section is effective August 1, 2017.

588.14 Sec. 48. **[245G.14] TRAINING REQUIREMENTS.**

588.15 Subdivision 1. **First aid and cardiopulmonary resuscitation.** At least one designated
588.16 staff person who completed pediatric first aid training and pediatric cardiopulmonary
588.17 resuscitation (CPR) training must be present at all times at the program, during field trips,
588.18 and when transporting a child. The designated staff person must repeat pediatric first aid
588.19 training and pediatric CPR training at least once every two years.

588.20 Subd. 2. **Sudden unexpected infant death.** A certified center that cares for an infant
588.21 who is younger than one year of age must ensure that staff persons and volunteers receive
588.22 training according to section 245A.1435 on reducing the risk of sudden unexpected infant
588.23 death before assisting in the care of an infant.

588.24 Subd. 3. **Abusive head trauma.** A certified center that cares for a child through four
588.25 years of age must ensure that staff persons and volunteers receive training on abusive head
588.26 trauma from shaking infants and young children before assisting in the care of a child through
588.27 four years of age.

588.28 Subd. 4. **Child development.** The certified center must ensure each staff person completes
588.29 at least two hours of child development and learning training within 14 days of employment
588.30 and annually thereafter. For purposes of this subdivision, "child development and learning
588.31 training" means how a child develops physically, cognitively, emotionally, and socially and
588.32 learns as part of the child's family, culture, and community.

589.1 Subd. 5. **Orientation.** The certified center must ensure each staff person is trained at
589.2 orientation on health and safety requirements in sections 245G.11, 245G.13, 245G.14, and
589.3 245G.15. The certified center must provide staff with an orientation within 14 days of
589.4 employment. Before the completion of orientation, a staff person must be supervised while
589.5 providing direct care to a child.

589.6 Subd. 6. **In service.** (a) The certified center must ensure each staff person is trained at
589.7 least annually on health and safety requirements in sections 245G.11, 245G.13, 245G.14,
589.8 and 245G.15.

589.9 (b) Each staff person must annually complete at least six hours of training. Training
589.10 required under paragraph (a) may be used toward the hourly training requirements of this
589.11 subdivision.

589.12 Subd. 7. **Documentation.** A certified center must document the date of a completed
589.13 training required by this section in the personnel record of each staff person.

589.14 **EFFECTIVE DATE.** This section is effective the day following final enactment.

589.15 Sec. 49. **[245G.15] EMERGENCY PREPAREDNESS.**

589.16 Subdivision 1. **Written emergency plan.** (a) A certified center must have a written
589.17 emergency plan for emergencies that require evacuation, sheltering, or other protection of
589.18 children, such as fire, natural disaster, intruder, or other threatening situation that may pose
589.19 a health or safety hazard to children. The plan must be written on a form developed by the
589.20 commissioner and reviewed and updated at least once each calendar year. The annual review
589.21 of the emergency plan must be documented.

589.22 (b) The plan must include:

589.23 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

589.24 (2) a designated relocation site and evacuation route;

589.25 (3) procedures for notifying a child's parent or legal guardian of the relocation and
589.26 reunification with families;

589.27 (4) accommodations for a child with a disability or a chronic medical condition;

589.28 (5) procedures for storing a child's medically necessary medicine that facilitates easy
589.29 removal during an evacuation or relocation;

589.30 (6) procedures for continuing operations in the period during and after a crisis; and

590.1 (7) procedures for communicating with local emergency management officials, law
590.2 enforcement officials, or other appropriate state or local authorities.

590.3 (c) The certification holder must have an emergency plan available for review upon
590.4 request by the child's parent or legal guardian.

590.5 Subd. 2. **Staff person training.** The certification holder must train a staff person at
590.6 orientation and at least once each calendar year on the emergency plan and document training
590.7 in each personnel file. The certified center must conduct at least quarterly one evacuation
590.8 drill and one shelter-in-place drill. The date and time of the drills must be documented.

590.9 **EFFECTIVE DATE.** This section is effective August 1, 2017.

590.10 Sec. 50. **[245G.16] PERSONNEL RECORD.**

590.11 The certification holder must maintain a personnel record for each staff person at the
590.12 program that must contain:

590.13 (1) the staff person's name, home address, telephone number, and date of birth;

590.14 (2) documentation that the staff person completed training required by section 245G.14;

590.15 (3) documentation of the date the program initiated a background study for the staff
590.16 person; and

590.17 (4) documentation of the date the staff person first had direct contact and access to a
590.18 child while supervised, and the date the staff person first had direct contact and access to a
590.19 child while unsupervised.

590.20 **EFFECTIVE DATE.** This section is effective August 1, 2017.

590.21 Sec. 51. **[245G.17] CERTIFICATION STANDARDS.**

590.22 The commissioner shall regularly consult with stakeholders for input related to
590.23 implementing the standards in this chapter.

590.24 **EFFECTIVE DATE.** This section is effective August 1, 2017.

590.25 Sec. 52. **[245G.18] PARENTAL ACCESS.**

590.26 An enrolled child's parent or legal guardian must be allowed access to the parent's or
590.27 legal guardian's child at any time while the child is in care.

590.28 **EFFECTIVE DATE.** This section is effective August 1, 2017.

591.1 Sec. 53. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

591.2 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
591.3 given them unless the specific content indicates otherwise:

591.4 (a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence
591.5 or event which:

591.6 (1) is not likely to occur and could not have been prevented by exercise of due care; and

591.7 (2) if occurring while a child is receiving services from a facility, happens when the
591.8 facility and the employee or person providing services in the facility are in compliance with
591.9 the laws and rules relevant to the occurrence or event.

591.10 (b) "Commissioner" means the commissioner of human services.

591.11 (c) "Facility" means:

591.12 (1) a licensed or unlicensed day care facility, certified license-exempt child care center,
591.13 residential facility, agency, hospital, sanitarium, or other facility or institution required to
591.14 be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter
591.15 245D or 245G;

591.16 (2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E;
591.17 or

591.18 (3) a nonlicensed personal care provider organization as defined in section 256B.0625,
591.19 subdivision 19a.

591.20 (d) "Family assessment" means a comprehensive assessment of child safety, risk of
591.21 subsequent child maltreatment, and family strengths and needs that is applied to a child
591.22 maltreatment report that does not allege sexual abuse or substantial child endangerment.
591.23 Family assessment does not include a determination as to whether child maltreatment
591.24 occurred but does determine the need for services to address the safety of family members
591.25 and the risk of subsequent maltreatment.

591.26 (e) "Investigation" means fact gathering related to the current safety of a child and the
591.27 risk of subsequent maltreatment that determines whether child maltreatment occurred and
591.28 whether child protective services are needed. An investigation must be used when reports
591.29 involve sexual abuse or substantial child endangerment, and for reports of maltreatment in
591.30 facilities required to be licensed or certified under chapter 245A ~~or~~ 245D, or 245G; under
591.31 sections 144.50 to 144.58 and 241.021; in a school as defined in section 120A.05,

592.1 subdivisions 9, 11, and 13, and chapter 124E; or in a nonlicensed personal care provider
592.2 association as defined in section 256B.0625, subdivision 19a.

592.3 (f) "Mental injury" means an injury to the psychological capacity or emotional stability
592.4 of a child as evidenced by an observable or substantial impairment in the child's ability to
592.5 function within a normal range of performance and behavior with due regard to the child's
592.6 culture.

592.7 (g) "Neglect" means the commission or omission of any of the acts specified under
592.8 clauses (1) to (9), other than by accidental means:

592.9 (1) failure by a person responsible for a child's care to supply a child with necessary
592.10 food, clothing, shelter, health, medical, or other care required for the child's physical or
592.11 mental health when reasonably able to do so;

592.12 (2) failure to protect a child from conditions or actions that seriously endanger the child's
592.13 physical or mental health when reasonably able to do so, including a growth delay, which
592.14 may be referred to as a failure to thrive, that has been diagnosed by a physician and is due
592.15 to parental neglect;

592.16 (3) failure to provide for necessary supervision or child care arrangements appropriate
592.17 for a child after considering factors as the child's age, mental ability, physical condition,
592.18 length of absence, or environment, when the child is unable to care for the child's own basic
592.19 needs or safety, or the basic needs or safety of another child in their care;

592.20 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
592.21 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
592.22 child with sympathomimetic medications, consistent with section 125A.091, subdivision
592.23 5;

592.24 (5) nothing in this section shall be construed to mean that a child is neglected solely
592.25 because the child's parent, guardian, or other person responsible for the child's care in good
592.26 faith selects and depends upon spiritual means or prayer for treatment or care of disease or
592.27 remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker,
592.28 or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of
592.29 medical care may cause serious danger to the child's health. This section does not impose
592.30 upon persons, not otherwise legally responsible for providing a child with necessary food,
592.31 clothing, shelter, education, or medical care, a duty to provide that care;

592.32 (6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision
592.33 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in

593.1 the child at birth, results of a toxicology test performed on the mother at delivery or the
593.2 child at birth, medical effects or developmental delays during the child's first year of life
593.3 that medically indicate prenatal exposure to a controlled substance, or the presence of a
593.4 fetal alcohol spectrum disorder;

593.5 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

593.6 (8) chronic and severe use of alcohol or a controlled substance by a parent or person
593.7 responsible for the care of the child that adversely affects the child's basic needs and safety;
593.8 or

593.9 (9) emotional harm from a pattern of behavior which contributes to impaired emotional
593.10 functioning of the child which may be demonstrated by a substantial and observable effect
593.11 in the child's behavior, emotional response, or cognition that is not within the normal range
593.12 for the child's age and stage of development, with due regard to the child's culture.

593.13 (h) "Nonmaltreatment mistake" means:

593.14 (1) at the time of the incident, the individual was performing duties identified in the
593.15 center's child care program plan required under Minnesota Rules, part 9503.0045;

593.16 (2) the individual has not been determined responsible for a similar incident that resulted
593.17 in a finding of maltreatment for at least seven years;

593.18 (3) the individual has not been determined to have committed a similar nonmaltreatment
593.19 mistake under this paragraph for at least four years;

593.20 (4) any injury to a child resulting from the incident, if treated, is treated only with
593.21 remedies that are available over the counter, whether ordered by a medical professional or
593.22 not; and

593.23 (5) except for the period when the incident occurred, the facility and the individual
593.24 providing services were both in compliance with all licensing requirements relevant to the
593.25 incident.

593.26 This definition only applies to child care centers licensed under Minnesota Rules, chapter
593.27 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated
593.28 maltreatment by the individual, the commissioner of human services shall determine that a
593.29 nonmaltreatment mistake was made by the individual.

593.30 (i) "Operator" means an operator or agency as defined in section 245A.02.

593.31 (j) "Person responsible for the child's care" means (1) an individual functioning within
593.32 the family unit and having responsibilities for the care of the child such as a parent, guardian,

594.1 or other person having similar care responsibilities, or (2) an individual functioning outside
594.2 the family unit and having responsibilities for the care of the child such as a teacher, school
594.3 administrator, other school employees or agents, or other lawful custodian of a child having
594.4 either full-time or short-term care responsibilities including, but not limited to, day care,
594.5 babysitting whether paid or unpaid, counseling, teaching, and coaching.

594.6 (k) "Physical abuse" means any physical injury, mental injury, or threatened injury,
594.7 inflicted by a person responsible for the child's care on a child other than by accidental
594.8 means, or any physical or mental injury that cannot reasonably be explained by the child's
594.9 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
594.10 that have not been authorized under section 125A.0942 or 245.825.

594.11 Abuse does not include reasonable and moderate physical discipline of a child
594.12 administered by a parent or legal guardian which does not result in an injury. Abuse does
594.13 not include the use of reasonable force by a teacher, principal, or school employee as allowed
594.14 by section 121A.582. Actions which are not reasonable and moderate include, but are not
594.15 limited to, any of the following:

594.16 (1) throwing, kicking, burning, biting, or cutting a child;

594.17 (2) striking a child with a closed fist;

594.18 (3) shaking a child under age three;

594.19 (4) striking or other actions which result in any nonaccidental injury to a child under 18
594.20 months of age;

594.21 (5) unreasonable interference with a child's breathing;

594.22 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

594.23 (7) striking a child under age one on the face or head;

594.24 (8) striking a child who is at least age one but under age four on the face or head, which
594.25 results in an injury;

594.26 (9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
594.27 substances which were not prescribed for the child by a practitioner, in order to control or
594.28 punish the child; or other substances that substantially affect the child's behavior, motor
594.29 coordination, or judgment or that results in sickness or internal injury, or subjects the child
594.30 to medical procedures that would be unnecessary if the child were not exposed to the
594.31 substances;

595.1 (10) unreasonable physical confinement or restraint not permitted under section 609.379,
595.2 including but not limited to tying, caging, or chaining; or

595.3 (11) in a school facility or school zone, an act by a person responsible for the child's
595.4 care that is a violation under section 121A.58.

595.5 (l) "Practice of social services," for the purposes of subdivision 3, includes but is not
595.6 limited to employee assistance counseling and the provision of guardian ad litem and
595.7 parenting time expeditor services.

595.8 (m) "Report" means any communication received by the local welfare agency, police
595.9 department, county sheriff, or agency responsible for child protection pursuant to this section
595.10 that describes neglect or physical or sexual abuse of a child and contains sufficient content
595.11 to identify the child and any person believed to be responsible for the neglect or abuse, if
595.12 known.

595.13 (n) "Sexual abuse" means the subjection of a child by a person responsible for the child's
595.14 care, by a person who has a significant relationship to the child, as defined in section 609.341,
595.15 or by a person in a position of authority, as defined in section 609.341, subdivision 10, to
595.16 any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first
595.17 degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual
595.18 conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or
595.19 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act
595.20 which involves a minor which constitutes a violation of prostitution offenses under sections
595.21 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports
595.22 of known or suspected child sex trafficking involving a child who is identified as a victim
595.23 of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321,
595.24 subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the
595.25 status of a parent or household member who has committed a violation which requires
595.26 registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or
595.27 required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

595.28 (o) "Substantial child endangerment" means a person responsible for a child's care, by
595.29 act or omission, commits or attempts to commit an act against a child under their care that
595.30 constitutes any of the following:

595.31 (1) egregious harm as defined in section 260C.007, subdivision 14;

595.32 (2) abandonment under section 260C.301, subdivision 2;

596.1 (3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's
596.2 physical or mental health, including a growth delay, which may be referred to as failure to
596.3 thrive, that has been diagnosed by a physician and is due to parental neglect;

596.4 (4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

596.5 (5) manslaughter in the first or second degree under section 609.20 or 609.205;

596.6 (6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

596.7 (7) solicitation, inducement, and promotion of prostitution under section 609.322;

596.8 (8) criminal sexual conduct under sections 609.342 to 609.3451;

596.9 (9) solicitation of children to engage in sexual conduct under section 609.352;

596.10 (10) malicious punishment or neglect or endangerment of a child under section 609.377
596.11 or 609.378;

596.12 (11) use of a minor in sexual performance under section 617.246; or

596.13 (12) parental behavior, status, or condition which mandates that the county attorney file
596.14 a termination of parental rights petition under section 260C.503, subdivision 2.

596.15 (p) "Threatened injury" means a statement, overt act, condition, or status that represents
596.16 a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes,
596.17 but is not limited to, exposing a child to a person responsible for the child's care, as defined
596.18 in paragraph (j), clause (1), who has:

596.19 (1) subjected a child to, or failed to protect a child from, an overt act or condition that
596.20 constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law
596.21 of another jurisdiction;

596.22 (2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph
596.23 (b), clause (4), or a similar law of another jurisdiction;

596.24 (3) committed an act that has resulted in an involuntary termination of parental rights
596.25 under section 260C.301, or a similar law of another jurisdiction; or

596.26 (4) committed an act that has resulted in the involuntary transfer of permanent legal and
596.27 physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201,
596.28 subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law
596.29 of another jurisdiction.

597.1 A child is the subject of a report of threatened injury when the responsible social services
597.2 agency receives birth match data under paragraph (q) from the Department of Human
597.3 Services.

597.4 (q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth
597.5 record or recognition of parentage identifying a child who is subject to threatened injury
597.6 under paragraph (p), the Department of Human Services shall send the data to the responsible
597.7 social services agency. The data is known as "birth match" data. Unless the responsible
597.8 social services agency has already begun an investigation or assessment of the report due
597.9 to the birth of the child or execution of the recognition of parentage and the parent's previous
597.10 history with child protection, the agency shall accept the birth match data as a report under
597.11 this section. The agency may use either a family assessment or investigation to determine
597.12 whether the child is safe. All of the provisions of this section apply. If the child is determined
597.13 to be safe, the agency shall consult with the county attorney to determine the appropriateness
597.14 of filing a petition alleging the child is in need of protection or services under section
597.15 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is
597.16 determined not to be safe, the agency and the county attorney shall take appropriate action
597.17 as required under section 260C.503, subdivision 2.

597.18 (r) Persons who conduct assessments or investigations under this section shall take into
597.19 account accepted child-rearing practices of the culture in which a child participates and
597.20 accepted teacher discipline practices, which are not injurious to the child's health, welfare,
597.21 and safety.

597.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

597.23 Sec. 54. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

597.24 Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person
597.25 who knows or has reason to believe a child is being neglected or physically or sexually
597.26 abused, as defined in subdivision 2, or has been neglected or physically or sexually abused
597.27 within the preceding three years, shall immediately report the information to the local welfare
597.28 agency, agency responsible for assessing or investigating the report, police department,
597.29 county sheriff, tribal social services agency, or tribal police department if the person is:

597.30 (1) a professional or professional's delegate who is engaged in the practice of the healing
597.31 arts, social services, hospital administration, psychological or psychiatric treatment, child
597.32 care, education, correctional supervision, probation and correctional services, or law
597.33 enforcement; or

598.1 (2) employed as a member of the clergy and received the information while engaged in
 598.2 ministerial duties, provided that a member of the clergy is not required by this subdivision
 598.3 to report information that is otherwise privileged under section 595.02, subdivision 1,
 598.4 paragraph (c).

598.5 (b) Any person may voluntarily report to the local welfare agency, agency responsible
 598.6 for assessing or investigating the report, police department, county sheriff, tribal social
 598.7 services agency, or tribal police department if the person knows, has reason to believe, or
 598.8 suspects a child is being or has been neglected or subjected to physical or sexual abuse.

598.9 (c) A person mandated to report physical or sexual child abuse or neglect occurring
 598.10 within a licensed facility shall report the information to the agency responsible for licensing
 598.11 or certifying the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16;
 598.12 or chapter 245D or 245G; or a nonlicensed personal care provider organization as defined
 598.13 in section 256B.0625, subdivision 19. A health or corrections agency receiving a report
 598.14 may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a,
 598.15 and 10b. A board or other entity whose licensees perform work within a school facility,
 598.16 upon receiving a complaint of alleged maltreatment, shall provide information about the
 598.17 circumstances of the alleged maltreatment to the commissioner of education. Section 13.03,
 598.18 subdivision 4, applies to data received by the commissioner of education from a licensing
 598.19 entity.

598.20 (d) Notification requirements under subdivision 10 apply to all reports received under
 598.21 this section.

598.22 (e) For purposes of this section, "immediately" means as soon as possible but in no event
 598.23 longer than 24 hours.

598.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

598.25 Sec. 55. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

598.26 Subd. 3c. **Local welfare agency, Department of Human Services or Department of**
 598.27 **Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~
 598.28 local welfare agency is the agency responsible for assessing or investigating allegations of
 598.29 maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child
 598.30 care, ~~juvenile correctional facilities licensed under section 241.021 located in the local~~
 598.31 ~~welfare agency's county~~, and reports involving children served by an unlicensed personal
 598.32 care provider organization under section 256B.0659. Copies of findings related to personal

599.1 care provider organizations under section 256B.0659 must be forwarded to the Department
599.2 of Human Services provider enrollment.

599.3 (b) The Department of Human Services is the agency responsible for assessing or
599.4 investigating allegations of maltreatment in juvenile correctional facilities listed under
599.5 section 241.021 located in the local welfare agency's county and in facilities licensed or
599.6 certified under chapters 245A ~~and~~, 245D, and 245G, except for child foster care and family
599.7 child care.

599.8 (c) The Department of Health is the agency responsible for assessing or investigating
599.9 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
599.10 144A.43 to 144A.482.

599.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

599.12 Sec. 56. Minnesota Statutes 2016, section 626.556, subdivision 4, is amended to read:

599.13 Subd. 4. **Immunity from liability.** (a) The following persons are immune from any civil
599.14 or criminal liability that otherwise might result from their actions, if they are acting in good
599.15 faith:

599.16 (1) any person making a voluntary or mandated report under subdivision 3 or under
599.17 section 626.5561 or assisting in an assessment under this section or under section 626.5561;

599.18 (2) any person with responsibility for performing duties under this section or supervisor
599.19 employed by a local welfare agency, the commissioner of an agency responsible for operating
599.20 or supervising a licensed or unlicensed day care facility, residential facility, agency, hospital,
599.21 sanitarium, or other facility or institution required to be licensed or certified under sections
599.22 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B; or 245G; or a school as
599.23 defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed
599.24 personal care provider organization as defined in section 256B.0625, subdivision 19a,
599.25 complying with subdivision 10d; and

599.26 (3) any public or private school, facility as defined in subdivision 2, or the employee of
599.27 any public or private school or facility who permits access by a local welfare agency, the
599.28 Department of Education, or a local law enforcement agency and assists in an investigation
599.29 or assessment pursuant to subdivision 10 or under section 626.5561.

599.30 (b) A person who is a supervisor or person with responsibility for performing duties
599.31 under this section employed by a local welfare agency, the commissioner of human services,
599.32 or the commissioner of education complying with subdivisions 10 and 11 or section 626.5561
599.33 or any related rule or provision of law is immune from any civil or criminal liability that

600.1 might otherwise result from the person's actions, if the person is (1) acting in good faith
600.2 and exercising due care, or (2) acting in good faith and following the information collection
600.3 procedures established under subdivision 10, paragraphs (h), (i), and (j).

600.4 (c) This subdivision does not provide immunity to any person for failure to make a
600.5 required report or for committing neglect, physical abuse, or sexual abuse of a child.

600.6 (d) If a person who makes a voluntary or mandatory report under subdivision 3 prevails
600.7 in a civil action from which the person has been granted immunity under this subdivision,
600.8 the court may award the person attorney fees and costs.

600.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

600.10 Sec. 57. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

600.11 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received
600.12 that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the
600.13 care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
600.14 sanitarium, or other facility or institution required to be licensed or certified according to
600.15 sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 245D or 245G, or
600.16 a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a
600.17 nonlicensed personal care provider organization as defined in section 256B.0625, subdivision
600.18 19a, the commissioner of the agency responsible for assessing or investigating the report
600.19 or local welfare agency investigating the report shall provide the following information to
600.20 the parent, guardian, or legal custodian of a child alleged to have been neglected, physically
600.21 abused, sexually abused, or the victim of maltreatment of a child in the facility: the name
600.22 of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or
600.23 maltreatment of a child in the facility has been received; the nature of the alleged neglect,
600.24 physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is
600.25 conducting an assessment or investigation; any protective or corrective measures being
600.26 taken pending the outcome of the investigation; and that a written memorandum will be
600.27 provided when the investigation is completed.

600.28 (b) The commissioner of the agency responsible for assessing or investigating the report
600.29 or local welfare agency may also provide the information in paragraph (a) to the parent,
600.30 guardian, or legal custodian of any other child in the facility if the investigative agency
600.31 knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or
600.32 maltreatment of a child in the facility has occurred. In determining whether to exercise this
600.33 authority, the commissioner of the agency responsible for assessing or investigating the
600.34 report or local welfare agency shall consider the seriousness of the alleged neglect, physical

601.1 abuse, sexual abuse, or maltreatment of a child in the facility; the number of children
601.2 allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a
601.3 child in the facility; the number of alleged perpetrators; and the length of the investigation.
601.4 The facility shall be notified whenever this discretion is exercised.

601.5 (c) When the commissioner of the agency responsible for assessing or investigating the
601.6 report or local welfare agency has completed its investigation, every parent, guardian, or
601.7 legal custodian previously notified of the investigation by the commissioner or local welfare
601.8 agency shall be provided with the following information in a written memorandum: the
601.9 name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual
601.10 abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the
601.11 investigation findings; a statement whether maltreatment was found; and the protective or
601.12 corrective measures that are being or will be taken. The memorandum shall be written in a
601.13 manner that protects the identity of the reporter and the child and shall not contain the name,
601.14 or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed
601.15 during the investigation. If maltreatment is determined to exist, the commissioner or local
601.16 welfare agency shall also provide the written memorandum to the parent, guardian, or legal
601.17 custodian of each child in the facility who had contact with the individual responsible for
601.18 the maltreatment. When the facility is the responsible party for maltreatment, the
601.19 commissioner or local welfare agency shall also provide the written memorandum to the
601.20 parent, guardian, or legal custodian of each child who received services in the population
601.21 of the facility where the maltreatment occurred. This notification must be provided to the
601.22 parent, guardian, or legal custodian of each child receiving services from the time the
601.23 maltreatment occurred until either the individual responsible for maltreatment is no longer
601.24 in contact with a child or children in the facility or the conclusion of the investigation. In
601.25 the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions
601.26 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification
601.27 to parents, guardians, or legal custodians of each child in the facility, but shall, within ten
601.28 days after the investigation is completed, provide written notification to the parent, guardian,
601.29 or legal custodian of any student alleged to have been maltreated. The commissioner of
601.30 education may notify the parent, guardian, or legal custodian of any student involved as a
601.31 witness to alleged maltreatment.

601.32 **EFFECTIVE DATE.** This section is effective the day following final enactment.

602.1 Sec. 58. Minnesota Statutes 2016, section 626.556, subdivision 10e, is amended to read:

602.2 Subd. 10e. **Determinations.** (a) The local welfare agency shall conclude the family
602.3 assessment or the investigation within 45 days of the receipt of a report. The conclusion of
602.4 the assessment or investigation may be extended to permit the completion of a criminal
602.5 investigation or the receipt of expert information requested within 45 days of the receipt of
602.6 the report.

602.7 (b) After conducting a family assessment, the local welfare agency shall determine
602.8 whether services are needed to address the safety of the child and other family members
602.9 and the risk of subsequent maltreatment.

602.10 (c) After conducting an investigation, the local welfare agency shall make two
602.11 determinations: first, whether maltreatment has occurred; and second, whether child
602.12 protective services are needed. No determination of maltreatment shall be made when the
602.13 alleged perpetrator is a child under the age of ten.

602.14 (d) If the commissioner of education conducts an assessment or investigation, the
602.15 commissioner shall determine whether maltreatment occurred and what corrective or
602.16 protective action was taken by the school facility. If a determination is made that
602.17 maltreatment has occurred, the commissioner shall report to the employer, the school board,
602.18 and any appropriate licensing entity the determination that maltreatment occurred and what
602.19 corrective or protective action was taken by the school facility. In all other cases, the
602.20 commissioner shall inform the school board or employer that a report was received, the
602.21 subject of the report, the date of the initial report, the category of maltreatment alleged as
602.22 defined in paragraph (f), the fact that maltreatment was not determined, and a summary of
602.23 the specific reasons for the determination.

602.24 (e) When maltreatment is determined in an investigation involving a facility, the
602.25 investigating agency shall also determine whether the facility or individual was responsible,
602.26 or whether both the facility and the individual were responsible for the maltreatment using
602.27 the mitigating factors in paragraph (i). Determinations under this subdivision must be made
602.28 based on a preponderance of the evidence and are private data on individuals or nonpublic
602.29 data as maintained by the commissioner of education.

602.30 (f) For the purposes of this subdivision, "maltreatment" means any of the following acts
602.31 or omissions:

602.32 (1) physical abuse as defined in subdivision 2, paragraph (k);

602.33 (2) neglect as defined in subdivision 2, paragraph (g);

603.1 (3) sexual abuse as defined in subdivision 2, paragraph (n);

603.2 (4) mental injury as defined in subdivision 2, paragraph (f); or

603.3 (5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (c).

603.4 (g) For the purposes of this subdivision, a determination that child protective services
603.5 are needed means that the local welfare agency has documented conditions during the
603.6 assessment or investigation sufficient to cause a child protection worker, as defined in
603.7 section 626.559, subdivision 1, to conclude that a child is at significant risk of maltreatment
603.8 if protective intervention is not provided and that the individuals responsible for the child's
603.9 care have not taken or are not likely to take actions to protect the child from maltreatment
603.10 or risk of maltreatment.

603.11 (h) This subdivision does not mean that maltreatment has occurred solely because the
603.12 child's parent, guardian, or other person responsible for the child's care in good faith selects
603.13 and depends upon spiritual means or prayer for treatment or care of disease or remedial care
603.14 of the child, in lieu of medical care. However, if lack of medical care may result in serious
603.15 danger to the child's health, the local welfare agency may ensure that necessary medical
603.16 services are provided to the child.

603.17 (i) When determining whether the facility or individual is the responsible party, or
603.18 whether both the facility and the individual are responsible for determined maltreatment in
603.19 a facility, the investigating agency shall consider at least the following mitigating factors:

603.20 (1) whether the actions of the facility or the individual caregivers were according to,
603.21 and followed the terms of, an erroneous physician order, prescription, individual care plan,
603.22 or directive; however, this is not a mitigating factor when the facility or caregiver was
603.23 responsible for the issuance of the erroneous order, prescription, individual care plan, or
603.24 directive or knew or should have known of the errors and took no reasonable measures to
603.25 correct the defect before administering care;

603.26 (2) comparative responsibility between the facility, other caregivers, and requirements
603.27 placed upon an employee, including the facility's compliance with related regulatory standards
603.28 and the adequacy of facility policies and procedures, facility training, an individual's
603.29 participation in the training, the caregiver's supervision, and facility staffing levels and the
603.30 scope of the individual employee's authority and discretion; and

603.31 (3) whether the facility or individual followed professional standards in exercising
603.32 professional judgment.

604.1 The evaluation of the facility's responsibility under clause (2) must not be based on the
604.2 completeness of the risk assessment or risk reduction plan required under section 245A.66,
604.3 but must be based on the facility's compliance with the regulatory standards for policies
604.4 and procedures, training, and supervision as cited in Minnesota Statutes and Minnesota
604.5 Rules.

604.6 (j) Notwithstanding paragraph (i), when maltreatment is determined to have been
604.7 committed by an individual who is also the facility license or certification holder, both the
604.8 individual and the facility must be determined responsible for the maltreatment, and both
604.9 the background study disqualification standards under section 245C.15, subdivision 4, and
604.10 the licensing or certification actions under ~~sections~~ section 245A.06 ~~or~~, 245A.07, 245G.06,
604.11 or 245G.07 apply.

604.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

604.13 Sec. 59. Minnesota Statutes 2016, section 626.556, subdivision 10f, is amended to read:

604.14 Subd. 10f. **Notice of determinations.** Within ten working days of the conclusion of a
604.15 family assessment, the local welfare agency shall notify the parent or guardian of the child
604.16 of the need for services to address child safety concerns or significant risk of subsequent
604.17 child maltreatment. The local welfare agency and the family may also jointly agree that
604.18 family support and family preservation services are needed. Within ten working days of the
604.19 conclusion of an investigation, the local welfare agency or agency responsible for
604.20 investigating the report shall notify the parent or guardian of the child, the person determined
604.21 to be maltreating the child, and, if applicable, the director of the facility, of the determination
604.22 and a summary of the specific reasons for the determination. When the investigation involves
604.23 a child foster care setting that is monitored by a private licensing agency under section
604.24 245A.16, the local welfare agency responsible for investigating the report shall notify the
604.25 private licensing agency of the determination and shall provide a summary of the specific
604.26 reasons for the determination. The notice to the private licensing agency must include
604.27 identifying private data, but not the identity of the reporter of maltreatment. The notice must
604.28 also include a certification that the information collection procedures under subdivision 10,
604.29 paragraphs (h), (i), and (j), were followed and a notice of the right of a data subject to obtain
604.30 access to other private data on the subject collected, created, or maintained under this section.
604.31 In addition, the notice shall include the length of time that the records will be kept under
604.32 subdivision 11c. The investigating agency shall notify the parent or guardian of the child
604.33 who is the subject of the report, and any person or facility determined to have maltreated a
604.34 child, of their appeal or review rights under this section. The notice must also state that a

605.1 finding of maltreatment may result in denial of a license or certification application or
605.2 background study disqualification under chapter 245C related to employment or services
605.3 that are licensed or certified by the Department of Human Services under chapter 245A or
605.4 245G, the Department of Health under chapter 144 or 144A, the Department of Corrections
605.5 under section 241.021, and from providing services related to an unlicensed personal care
605.6 provider organization under chapter 256B.

605.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

605.8 Sec. 60. Minnesota Statutes 2016, section 626.556, subdivision 10i, is amended to read:

605.9 Subd. 10i. **Administrative reconsideration; review panel.** (a) Administrative
605.10 reconsideration is not applicable in family assessments since no determination concerning
605.11 maltreatment is made. For investigations, except as provided under paragraph (e), an
605.12 individual or facility that the commissioner of human services, a local social service agency,
605.13 or the commissioner of education determines has maltreated a child, an interested person
605.14 acting on behalf of the child, regardless of the determination, who contests the investigating
605.15 agency's final determination regarding maltreatment, may request the investigating agency
605.16 to reconsider its final determination regarding maltreatment. The request for reconsideration
605.17 must be submitted in writing to the investigating agency within 15 calendar days after receipt
605.18 of notice of the final determination regarding maltreatment or, if the request is made by an
605.19 interested person who is not entitled to notice, within 15 days after receipt of the notice by
605.20 the parent or guardian of the child. If mailed, the request for reconsideration must be
605.21 postmarked and sent to the investigating agency within 15 calendar days of the individual's
605.22 or facility's receipt of the final determination. If the request for reconsideration is made by
605.23 personal service, it must be received by the investigating agency within 15 calendar days
605.24 after the individual's or facility's receipt of the final determination. Effective January 1,
605.25 2002, an individual who was determined to have maltreated a child under this section and
605.26 who was disqualified on the basis of serious or recurring maltreatment under sections
605.27 245C.14 and 245C.15, may request reconsideration of the maltreatment determination and
605.28 the disqualification. The request for reconsideration of the maltreatment determination and
605.29 the disqualification must be submitted within 30 calendar days of the individual's receipt
605.30 of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request
605.31 for reconsideration of the maltreatment determination and the disqualification must be
605.32 postmarked and sent to the investigating agency within 30 calendar days of the individual's
605.33 receipt of the maltreatment determination and notice of disqualification. If the request for
605.34 reconsideration is made by personal service, it must be received by the investigating agency
605.35 within 30 calendar days after the individual's receipt of the notice of disqualification.

606.1 (b) Except as provided under paragraphs (e) and (f), if the investigating agency denies
606.2 the request or fails to act upon the request within 15 working days after receiving the request
606.3 for reconsideration, the person or facility entitled to a fair hearing under section 256.045
606.4 may submit to the commissioner of human services or the commissioner of education a
606.5 written request for a hearing under that section. Section 256.045 also governs hearings
606.6 requested to contest a final determination of the commissioner of education. The investigating
606.7 agency shall notify persons who request reconsideration of their rights under this paragraph.
606.8 The hearings specified under this section are the only administrative appeal of a decision
606.9 issued under paragraph (a). Determinations under this section are not subject to accuracy
606.10 and completeness challenges under section 13.04.

606.11 (c) If, as a result of a reconsideration or review, the investigating agency changes the
606.12 final determination of maltreatment, that agency shall notify the parties specified in
606.13 subdivisions 10b, 10d, and 10f.

606.14 (d) Except as provided under paragraph (f), if an individual or facility contests the
606.15 investigating agency's final determination regarding maltreatment by requesting a fair
606.16 hearing under section 256.045, the commissioner of human services shall assure that the
606.17 hearing is conducted and a decision is reached within 90 days of receipt of the request for
606.18 a hearing. The time for action on the decision may be extended for as many days as the
606.19 hearing is postponed or the record is held open for the benefit of either party.

606.20 (e) If an individual was disqualified under sections 245C.14 and 245C.15, on the basis
606.21 of a determination of maltreatment, which was serious or recurring, and the individual has
606.22 requested reconsideration of the maltreatment determination under paragraph (a) and
606.23 requested reconsideration of the disqualification under sections 245C.21 to 245C.27,
606.24 reconsideration of the maltreatment determination and reconsideration of the disqualification
606.25 shall be consolidated into a single reconsideration. If reconsideration of the maltreatment
606.26 determination is denied and the individual remains disqualified following a reconsideration
606.27 decision, the individual may request a fair hearing under section 256.045. If an individual
606.28 requests a fair hearing on the maltreatment determination and the disqualification, the scope
606.29 of the fair hearing shall include both the maltreatment determination and the disqualification.

606.30 (f) If a maltreatment determination or a disqualification based on serious or recurring
606.31 maltreatment is the basis for a denial of a license under section 245A.05 or a licensing
606.32 sanction under section 245A.07, the license holder has the right to a contested case hearing
606.33 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. As provided for
606.34 under section 245A.08, subdivision 2a, the scope of the contested case hearing shall include
606.35 the maltreatment determination, disqualification, and licensing sanction or denial of a license.

607.1 In such cases, a fair hearing regarding the maltreatment determination and disqualification
607.2 shall not be conducted under section 256.045. Except for family child care and child foster
607.3 care, reconsideration of a maltreatment determination as provided under this subdivision,
607.4 and reconsideration of a disqualification as provided under section 245C.22, shall also not
607.5 be conducted when:

607.6 (1) a denial of a license under section 245A.05 or a licensing sanction under section
607.7 245A.07, is based on a determination that the license holder is responsible for maltreatment
607.8 or the disqualification of a license holder based on serious or recurring maltreatment;

607.9 (2) the denial of a license or licensing sanction is issued at the same time as the
607.10 maltreatment determination or disqualification; and

607.11 (3) the license holder appeals the maltreatment determination or disqualification, and
607.12 denial of a license or licensing sanction.

607.13 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
607.14 determination or disqualification, but does not appeal the denial of a license or a licensing
607.15 sanction, reconsideration of the maltreatment determination shall be conducted under sections
607.16 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
607.17 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall
607.18 also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
607.19 626.557, subdivision 9d.

607.20 If the disqualified subject is an individual other than the license holder and upon whom
607.21 a background study must be conducted under chapter 245C, the hearings of all parties may
607.22 be consolidated into a single contested case hearing upon consent of all parties and the
607.23 administrative law judge.

607.24 (g) For purposes of this subdivision, "interested person acting on behalf of the child"
607.25 means a parent or legal guardian; stepparent; grandparent; guardian ad litem; adult
607.26 stepbrother, stepsister, or sibling; or adult aunt or uncle; unless the person has been
607.27 determined to be the perpetrator of the maltreatment.

607.28 (h) If a maltreatment determination is the basis for a correction order under section
607.29 245G.06 or decertification under section 245G.07, the certification holder has the right to
607.30 request reconsideration under sections 245G.06 and 245G.07. If the certification holder
607.31 appeals the maltreatment determination or disqualification, but does not appeal the correction
607.32 order or decertification, reconsideration of the maltreatment determination shall be conducted
607.33 under section 626.556, subdivision 10i, and reconsideration of the disqualification shall be
607.34 conducted under section 245C.22.

608.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

608.2 **ARTICLE 17**

608.3 **HUMAN SERVICES FORECAST ADJUSTMENTS**

608.4 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

608.5 The dollar amounts shown are added to or, if shown in parentheses, are subtracted from
608.6 the appropriations in Laws 2015, chapter 71, article 14, as amended by Laws 2016, chapter
608.7 189, articles 22 and 23, from the general fund, or any other fund named, to the Department
608.8 of Human Services for the purposes specified in this article, to be available for the fiscal
608.9 years indicated for each purpose. The figure "2017" used in this article means that the
608.10 appropriations listed are available for the fiscal year ending June 30, 2017.

608.11 **APPROPRIATIONS**
608.12 **Available for the Year**
608.13 **Ending June 30**
608.14 **2017**

608.15 Sec. 2. **COMMISSIONER OF HUMAN**
608.16 **SERVICES**

608.17 Subdivision 1. **Total Appropriation** **\$ (342,045,000)**

608.18 **Appropriations by Fund**

608.19	<u>2017</u>	
608.20	<u>General Fund</u>	<u>(198,450,000)</u>
608.21	<u>Health Care Access</u>	<u>(146,590,000)</u>
608.22	<u>TANF</u>	<u>2,995,000</u>

608.23 Subd. 2. **Forecasted Programs**

608.24 **(a) MFIP/DWP Grants**

608.25 **Appropriations by Fund**

608.26	<u>General Fund</u>	<u>(2,111,000)</u>
608.27	<u>TANF</u>	<u>2,579,000</u>

608.28 **(b) MFIP Child Care Assistance Grants** **(6,513,000)**

608.29 **(c) General Assistance Grants** **(4,219,000)**

608.30 **(d) Minnesota Supplemental Aid Grants** **(581,000)**

608.31 **(e) Group Residential Housing Grants** **(533,000)**

608.32 **(f) Northstar Care for Children** **2,613,000**

609.1 (g) MinnesotaCare Grants (145,883,000)

609.2 This appropriation is from the health care
609.3 access fund.

609.4 (h) Medical Assistance Grants

609.5 Appropriations by Fund

609.6 General Fund (192,744,000)

609.7 Health Care Access (707,000)

609.8 (i) Alternative Care Grants -0-

609.9 (j) CD Entitlement Grants 5,638,000

609.10 Subd. 3. Technical Activities 416,000

609.11 This appropriation is from the TANF fund.

609.12 Sec. 3. EFFECTIVE DATE.

609.13 Sections 1 and 2 are effective the day following final enactment.

609.14 **ARTICLE 18**

609.15 **APPROPRIATIONS**

609.16 Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

609.17 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
609.18 and for the purposes specified in this article. The appropriations are from the general fund,
609.19 or another named fund, and are available for the fiscal years indicated for each purpose.

609.20 The figures "2018" and "2019" used in this article mean that the appropriations listed under
609.21 them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively.

609.22 "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium"
609.23 is fiscal years 2018 and 2019.

609.24 **APPROPRIATIONS**

609.25 **Available for the Year**

609.26 **Ending June 30**

609.27 **2018** **2019**

609.28 **Sec. 2. COMMISSIONER OF HUMAN**
609.29 **SERVICES**

610.1 Subdivision 1. Total Appropriation \$ 7,550,197,000 \$ 7,656,412,000

610.2 Appropriations by Fund

610.3	<u>2018</u>	<u>2019</u>
610.4	<u>6,819,523,000</u>	<u>6,880,153,000</u>
610.5		
610.6	<u>4,274,000</u>	<u>4,274,000</u>
610.7	<u>446,453,000</u>	<u>501,104,000</u>
610.8	<u>278,051,000</u>	<u>268,985,000</u>
610.9	<u>1,896,000</u>	<u>1,896,000</u>

610.10 The amounts that may be spent for each
 610.11 purpose are specified in the following
 610.12 subdivisions.

610.13 Subd. 2. TANF Maintenance of Effort

610.14 (a) The commissioner shall ensure that
 610.15 sufficient qualified nonfederal expenditures
 610.16 are made each year to meet the state's
 610.17 maintenance of effort (MOE) requirements of
 610.18 the TANF block grant specified under Code
 610.19 of Federal Regulations, title 45, section 263.1.
 610.20 In order to meet these basic TANF/MOE
 610.21 requirements, the commissioner may report
 610.22 as TANF/MOE expenditures only nonfederal
 610.23 money expended for allowable activities listed
 610.24 in the following clauses:

610.25 (1) MFIP cash, diversionary work program,
 610.26 and food assistance benefits under Minnesota
 610.27 Statutes, chapter 256J;

610.28 (2) the child care assistance programs under
 610.29 Minnesota Statutes, sections 119B.03 and
 610.30 119B.05, and county child care administrative
 610.31 costs under Minnesota Statutes, section
 610.32 119B.15;

610.33 (3) state and county MFIP administrative costs
 610.34 under Minnesota Statutes, chapters 256J and
 610.35 256K;

- 611.1 (4) state, county, and tribal MFIP employment
611.2 services under Minnesota Statutes, chapters
611.3 256J and 256K;
- 611.4 (5) expenditures made on behalf of legal
611.5 noncitizen MFIP recipients who qualify for
611.6 the MinnesotaCare program under Minnesota
611.7 Statutes, chapter 256L;
- 611.8 (6) qualifying working family credit
611.9 expenditures under Minnesota Statutes, section
611.10 290.0671;
- 611.11 (7) qualifying Minnesota education credit
611.12 expenditures under Minnesota Statutes, section
611.13 290.0674; and
- 611.14 (8) qualifying Head Start expenditures under
611.15 Minnesota Statutes, section 119A.50.
- 611.16 (b) For the activities listed in paragraph (a),
611.17 clauses (2) to (8), the commissioner may
611.18 report only expenditures that are excluded
611.19 from the definition of assistance under Code
611.20 of Federal Regulations, title 45, section
611.21 260.31.
- 611.22 (c) The commissioner shall ensure that the
611.23 MOE used by the commissioner of
611.24 management and budget for the February and
611.25 November forecasts required under Minnesota
611.26 Statutes, section 16A.103, contains
611.27 expenditures under paragraph (a), clause (1),
611.28 equal to at least 16 percent of the total required
611.29 under Code of Federal Regulations, title 45,
611.30 section 263.1.
- 611.31 (d) The commissioner may not claim an
611.32 amount of TANF/MOE in excess of the 75
611.33 percent standard in Code of Federal

612.1 Regulations, title 45, section 263.1(a)(2),
612.2 except:

612.3 (1) to the extent necessary to meet the 80
612.4 percent standard under Code of Federal
612.5 Regulations, title 45, section 263.1(a)(1), if it
612.6 is determined by the commissioner that the
612.7 state will not meet the TANF work
612.8 participation target rate for the current year;

612.9 (2) to provide any additional amounts under
612.10 Code of Federal Regulations, title 45, section
612.11 264.5, that relate to replacement of TANF
612.12 funds due to the operation of TANF penalties;
612.13 and

612.14 (3) to provide any additional amounts that may
612.15 contribute to avoiding or reducing TANF work
612.16 participation penalties through the operation
612.17 of the excess MOE provisions of Code of
612.18 Federal Regulations, title 45, section 261.43
612.19 (a)(2).

612.20 (e) For the purposes of paragraph (d), the
612.21 commissioner may supplement the MOE claim
612.22 with working family credit expenditures or
612.23 other qualified expenditures to the extent such
612.24 expenditures are otherwise available after
612.25 considering the expenditures allowed in this
612.26 subdivision.

612.27 (f) The requirement in Minnesota Statutes,
612.28 section 256.011, subdivision 3, that federal
612.29 grants or aids secured or obtained under that
612.30 subdivision be used to reduce any direct
612.31 appropriations provided by law, does not apply
612.32 if the grants or aids are federal TANF funds.

612.33 (g) **IT Appropriations Generally.** This
612.34 appropriation includes funds for information

- 613.1 technology projects, services, and support.
- 613.2 Notwithstanding Minnesota Statutes, section
- 613.3 16E.0466, funding for information technology
- 613.4 project costs shall be incorporated into the
- 613.5 service level agreement and paid to the Office
- 613.6 of MN.IT Services by the Department of
- 613.7 Human Services under the rates and
- 613.8 mechanism specified in that agreement.
- 613.9 **(h) Receipts for Systems Project.**
- 613.10 Appropriations and federal receipts for
- 613.11 information systems projects for MAXIS,
- 613.12 PRISM, MMIS, ISDS, METS, and SSIS must
- 613.13 be deposited in the state systems account
- 613.14 authorized in Minnesota Statutes, section
- 613.15 256.014. Money appropriated for computer
- 613.16 projects approved by the commissioner of the
- 613.17 Office of MN.IT Services, funded by the
- 613.18 legislature, and approved by the commissioner
- 613.19 of management and budget may be transferred
- 613.20 from one project to another and from
- 613.21 development to operations as the
- 613.22 commissioner of human services considers
- 613.23 necessary. Any unexpended balance in the
- 613.24 appropriation for these projects does not
- 613.25 cancel and is available for ongoing
- 613.26 development and operations.
- 613.27 **(i) Federal SNAP Education and Training**
- 613.28 **Grants.** Federal funds available during fiscal
- 613.29 years 2017, 2018, and 2019 for Supplemental
- 613.30 Nutrition Assistance Program Education and
- 613.31 Training and SNAP Quality Control
- 613.32 Performance Bonus grants are appropriated
- 613.33 to the commissioner of human services for the
- 613.34 purposes allowable under the terms of the

614.1 federal award. This paragraph is effective the
 614.2 day following final enactment.

614.3 **Subd. 3. Central Office; Operations**

614.4 Appropriations by Fund

614.5	<u>General</u>	<u>136,778,000</u>	<u>121,009,000</u>
614.6	<u>State Government</u>		
614.7	<u>Special Revenue</u>	<u>4,149,000</u>	<u>4,149,000</u>
614.8	<u>Health Care Access</u>	<u>21,019,000</u>	<u>21,019,000</u>
614.9	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

614.10 **(a) Administrative Recovery; Set-Aside.** The
 614.11 commissioner may invoice local entities
 614.12 through the SWIFT accounting system as an
 614.13 alternative means to recover the actual cost of
 614.14 administering the following provisions:

614.15 (1) Minnesota Statutes, section 125A.744,
 614.16 subdivision 3;

614.17 (2) Minnesota Statutes, section 245.495,
 614.18 paragraph (b);

614.19 (3) Minnesota Statutes, section 256B.0625,
 614.20 subdivision 20, paragraph (k);

614.21 (4) Minnesota Statutes, section 256B.0924,
 614.22 subdivision 6, paragraph (g);

614.23 (5) Minnesota Statutes, section 256B.0945,
 614.24 subdivision 4, paragraph (d); and

614.25 (6) Minnesota Statutes, section 256F.10,
 614.26 subdivision 6, paragraph (b).

614.27 **(b) Transfer to Office of Legislative**

614.28 **Auditor.** \$600,000 in fiscal year 2018 and
 614.29 \$600,000 in fiscal year 2019 are for transfer
 614.30 to the Office of the Legislative Auditor for
 614.31 audit activities under Minnesota Statutes,
 614.32 section 3.972, subdivision 2b.

615.1 (c) Base Level Adjustment. The general fund
 615.2 base is \$133,378,000 in fiscal year 2020 and
 615.3 \$133,418,000 in fiscal year 2021.

615.4 **Subd. 4. Central Office; Children and Families**

615.5	<u>Appropriations by Fund</u>	
615.6	<u>General</u>	<u>10,438,000</u> <u>10,431,000</u>
615.7	<u>Federal TANF</u>	<u>2,582,000</u> <u>2,582,000</u>

615.8 **Financial Institution Data Match and**
 615.9 **Payment of Fees.** The commissioner is
 615.10 authorized to allocate up to \$310,000 each
 615.11 year in fiscal year 2018 and fiscal year 2019
 615.12 from the systems special revenue account to
 615.13 make payments to financial institutions in
 615.14 exchange for performing data matches
 615.15 between account information held by financial
 615.16 institutions and the public authority's database
 615.17 of child support obligors as authorized by
 615.18 Minnesota Statutes, section 13B.06,
 615.19 subdivision 7.

615.20 **Subd. 5. Central Office; Health Care**

615.21	<u>Appropriations by Fund</u>	
615.22	<u>General</u>	<u>20,719,000</u> <u>21,249,000</u>
615.23	<u>Health Care Access</u>	<u>23,697,000</u> <u>23,804,000</u>

615.24 **(a) Integrated Health Partnership Health**
 615.25 **Information Exchange.** \$125,000 in fiscal
 615.26 year 2018 and \$250,000 in fiscal year 2019
 615.27 are from the general fund to contract with
 615.28 state-certified health information exchange
 615.29 vendors to support providers participating in
 615.30 an integrated health partnership under
 615.31 Minnesota Statutes, section 256B.0755, to
 615.32 connect enrollees with community supports
 615.33 and social services and improve collaboration
 615.34 among participating and authorized providers.

616.1 **(b) Transfer to Legislative Auditor. 153,000**
 616.2 in fiscal year 2018 and \$153,000 in fiscal year
 616.3 2019 are from the general fund for transfer to
 616.4 the Office of the Legislative Auditor for the
 616.5 auditor to establish and maintain a team of
 616.6 auditors with the training and experience
 616.7 necessary to fulfill the requirements in
 616.8 Minnesota Statutes, section 3.972, subdivision
 616.9 2a.

616.10 **(c) Base Level Adjustment. The general fund**
 616.11 base is \$21,257,000 in fiscal year 2020 and
 616.12 \$21,302,000 in fiscal year 2021.

616.13 **Subd. 6. Central Office; Continuing Care for**
 616.14 **Older Adults**

616.15	<u>Appropriations by Fund</u>		
616.16	<u>General</u>	<u>15,359,000</u>	<u>15,113,000</u>
616.17	<u>State Government</u>		
616.18	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

616.19 **(a) Alzheimer's Disease Working Group.**
 616.20 \$127,000 in fiscal year 2018 and \$110,000 in
 616.21 fiscal year 2019 are from the general fund for
 616.22 the Alzheimer's disease working group. This
 616.23 is a onetime appropriation.

616.24 **(b) Base Level Adjustment. The general fund**
 616.25 base is \$15,053,000 in fiscal year 2020 and
 616.26 \$15,053,000 in fiscal year 2021.

616.27 **Subd. 7. Central Office; Community Supports**

616.28	<u>Appropriations by Fund</u>		
616.29	<u>General</u>	<u>29,546,000</u>	<u>29,381,000</u>
616.30	<u>Lottery Prize</u>	<u>163,000</u>	<u>163,000</u>

616.31 **(a) Transportation Study. \$250,000 in fiscal**
 616.32 year 2018 and \$250,000 in fiscal year 2019
 616.33 are for a study to identify opportunities to
 616.34 increase access to transportation services for
 616.35 individuals who receive home and

617.1 community-based services. This is a onetime
617.2 appropriation.

617.3 **(b) Deaf and Hard-of-Hearing Services.**
617.4 \$438,000 in fiscal year 2018 and \$395,000 in
617.5 fiscal year 2019 are from the general fund for
617.6 the Deaf and Hard-of-Hearing Services
617.7 Division under Minnesota Statutes, section
617.8 256C.233.

617.9 **(c) Consumer-Directed Community**
617.10 **Supports Revised Budget Methodology**
617.11 **Report.** \$435,000 in fiscal year 2018 and
617.12 \$65,000 in fiscal year 2019 are from the
617.13 general fund to study and develop an
617.14 individual budgeting model for disability
617.15 waiver recipients and those accessing services
617.16 through consumer-directed community
617.17 supports. The commissioner shall submit
617.18 recommendations to the chairs and ranking
617.19 minority members of the legislative
617.20 committees with jurisdiction over these
617.21 programs by December 15, 2018. This is a
617.22 onetime appropriation.

617.23 **(d) Substance Use Disorder System Study.**
617.24 \$150,000 in fiscal year 2018 and \$150,000 in
617.25 fiscal year 2019 are for a substance use
617.26 disorder system study. This is a onetime
617.27 appropriation.

617.28 **(e) Children's Mental Health Report and**
617.29 **Recommendations.** \$125,000 in fiscal year
617.30 2018 and \$125,000 in fiscal year 2019 are for
617.31 a comprehensive analysis of Minnesota's
617.32 continuum of intensive mental health services
617.33 for children with serious mental health needs.
617.34 This is a onetime appropriation.

618.1 **(f) Self-Directed Workforce Collective**
 618.2 **Bargaining Agreement.** \$1,206,000 in fiscal
 618.3 year 2018 and \$1,206,000 in fiscal year 2019
 618.4 may be used for administration, training,
 618.5 grants, and reimbursement to implement a
 618.6 collective bargaining agreement between the
 618.7 state and the Service Employees International
 618.8 Union Healthcare Minnesota (SEIU). This
 618.9 appropriation is not available until the
 618.10 collective bargaining agreement between the
 618.11 state and SEIU under Minnesota Statutes,
 618.12 section 179A.54, is approved under
 618.13 subdivision 15, paragraph (b), clause (3). The
 618.14 commissioner may transfer funds between
 618.15 budget activities with the approval of the
 618.16 commissioner of management and budget.

618.17 **(g) Implementation and Operation of an**
 618.18 **Electronic Service Delivery Documentation**
 618.19 **System.** \$170,000 in fiscal year 2018 and
 618.20 \$105,000 in fiscal year 2019 are from the
 618.21 general fund for the development and
 618.22 implementation of an electronic service
 618.23 delivery documentation system. This is a
 618.24 onetime appropriation.

618.25 **(h) Base Level Adjustment.** The general fund
 618.26 base is \$27,504,000 in fiscal year 2020 and
 618.27 \$27,328,000 in fiscal year 2021.

618.28 **Subd. 8. Forecasted Programs; MFIP/DWP**

618.29	<u>Appropriations by Fund</u>	
618.30	<u>General</u>	<u>88,930,000</u> <u>98,251,000</u>
618.31	<u>Federal TANF</u>	<u>92,732,000</u> <u>83,513,000</u>

618.32	<u>Subd. 9. Forecasted Programs; MFIP Child Care</u>		
618.33	<u>Assistance</u>	<u>101,293,000</u>	<u>112,078,000</u>

618.34	<u>Subd. 10. Forecasted Programs; General</u>		
618.35	<u>Assistance</u>	<u>55,536,000</u>	<u>57,221,000</u>

619.1 **(a) General Assistance Standard.** The
 619.2 commissioner shall set the monthly standard
 619.3 of assistance for general assistance units
 619.4 consisting of an adult recipient who is
 619.5 childless and unmarried or living apart from
 619.6 parents or a legal guardian at \$203. The
 619.7 commissioner may reduce this amount
 619.8 according to Laws 1997, chapter 85, article 3,
 619.9 section 54.

619.10 **(b) Emergency General Assistance Limit.**
 619.11 The amount appropriated for emergency
 619.12 general assistance is limited to no more than
 619.13 \$6,729,812 in fiscal year 2018 and \$6,729,812
 619.14 in fiscal year 2019. Funds to counties shall be
 619.15 allocated by the commissioner using the
 619.16 allocation method under Minnesota Statutes,
 619.17 section 256D.06.

619.18 **Subd. 11. Forecasted Programs; Minnesota**
 619.19 **Supplemental Aid**

40,484,000

41,634,000

619.20 **Subd. 12. Forecasted Programs; Group**
 619.21 **Residential Housing**

169,312,000

179,643,000

619.22 **Eliminate Group Residential Housing**
 619.23 **Grant.** The forecasted base funding for the
 619.24 group residential housing program shall be
 619.25 reduced by \$460,000 in fiscal year 2018 and
 619.26 \$460,000 in fiscal year 2019 to reflect the
 619.27 elimination of grant funding for facilities
 619.28 under Minnesota Statutes, section 256I.05,
 619.29 subdivision 1m. The ongoing base funding
 619.30 shall be adjusted to reflect the elimination of
 619.31 this grant.

619.32 **Subd. 13. Forecasted Programs; Northstar Care**
 619.33 **for Children**

80,542,000

96,433,000

619.34 **Subd. 14. Forecasted Programs; MinnesotaCare**

12,363,000

13,218,000

620.1 This appropriation is from the health care
 620.2 access fund.

620.3 **Subd. 15. Forecasted Programs; Medical**
 620.4 **Assistance**

620.5 Appropriations by Fund

620.6 General 5,174,539,000 5,172,692,000

620.7 Health Care Access 385,159,000 438,848,000

620.8 **(a) Behavioral Health Services. \$1,000,000**

620.9 in fiscal year 2018 and \$1,000,000 in fiscal

620.10 year 2019 are for behavioral health services

620.11 provided by hospitals identified under

620.12 Minnesota Statutes, section 256.969,

620.13 subdivision 2b, paragraph (a), clause (4). The

620.14 increase in payments shall be made by

620.15 increasing the adjustment under Minnesota

620.16 Statutes, section 256.969, subdivision 2b,

620.17 paragraph (e), clause (2).

620.18 **(b) Self-Directed Workforce Collective**

620.19 **Bargaining Agreement. (1) This**

620.20 appropriation includes money to implement a

620.21 collective bargaining agreement between the

620.22 state and the Service Employees International

620.23 Union Healthcare Minnesota (SEIU). This

620.24 appropriation is not available until the

620.25 collective bargaining agreement between the

620.26 state of Minnesota and the Service Employees

620.27 International Union Healthcare Minnesota

620.28 under Minnesota Statutes, section 179A.54,

620.29 is approved as provided in clause (3).

620.30 **(2) The commissioner of management and**

620.31 **budget is authorized to negotiate and enter**

620.32 **into a collective bargaining agreement with**

620.33 **SEIU under Minnesota Statutes, section**

620.34 **179A.54, subject to the amount appropriated**

620.35 **in clause (1). The economic terms of the**

621.1	<u>collective bargaining agreement may include</u>		
621.2	<u>wage floor increases for direct support</u>		
621.3	<u>workers, paid time off, holiday pay, wage</u>		
621.4	<u>increases for workers serving people with</u>		
621.5	<u>complex needs, training stipends, and training</u>		
621.6	<u>for direct support workers and for</u>		
621.7	<u>implementation of the registry as outlined in</u>		
621.8	<u>the collective bargaining agreement.</u>		
621.9	<u>(3) Notwithstanding Minnesota Statutes,</u>		
621.10	<u>sections 3.855, 179A.22, subdivision 4, and</u>		
621.11	<u>179A.54, subdivision 5, upon approval of a</u>		
621.12	<u>negotiated collective bargaining agreement by</u>		
621.13	<u>the SEIU and the commissioner of</u>		
621.14	<u>management and budget, the commissioner</u>		
621.15	<u>of human services is authorized to implement</u>		
621.16	<u>the negotiated collective bargaining</u>		
621.17	<u>agreement.</u>		
621.18	<u>Subd. 16. Forecasted Programs; Alternative</u>		
621.19	<u>Care</u>	<u>44,258,000</u>	<u>44,976,000</u>
621.20	<u>Alternative Care Transfer.</u> Any money		
621.21	<u>allocated to the alternative care program that</u>		
621.22	<u>is not spent for the purposes indicated does</u>		
621.23	<u>not cancel but must be transferred to the</u>		
621.24	<u>medical assistance account.</u>		
621.25	<u>Subd. 17. Forecasted Programs; Chemical</u>		
621.26	<u>Dependency Treatment Fund</u>	<u>117,226,000</u>	<u>136,493,000</u>
621.27	<u>Subd. 18. Grant Programs; Support Services</u>		
621.28	<u>Grants</u>		
621.29	<u>Appropriations by Fund</u>		
621.30	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
621.31	<u>Federal TANF</u>	<u>96,311,000</u>	<u>96,311,000</u>
621.32	<u>Subd. 19. Grant Programs; Basic Sliding Fee</u>		
621.33	<u>Child Care Assistance Grants</u>	<u>44,690,000</u>	<u>53,413,000</u>
621.34	<u>(a) Maximum Rate for Certain Child Care</u>		
621.35	<u>Providers.</u> Notwithstanding Minnesota		
621.36	<u>Statutes, section 119B.03, subdivisions 6 and</u>		

622.1 6a, \$25,000 in fiscal year 2019 is to modify
 622.2 maximum rates for child care providers in a
 622.3 city with boundaries located in two or more
 622.4 of the counties of Benton, Sherburne, and
 622.5 Stearns. \$12,000 of the funding for the
 622.6 calendar year 2018 allocation and \$29,000 of
 622.7 the funding for the calendar year 2019
 622.8 allocation shall be allocated proportionally to
 622.9 the three counties based on county
 622.10 expenditures in the most recent calendar year.
 622.11 Allocations in calendar year 2020 and beyond
 622.12 shall be calculated using the allocation formula
 622.13 in Minnesota Statutes, section 119B.03,
 622.14 subdivision 6.

622.15 **(b) Base Level Adjustment.** The general fund
 622.16 base is \$53,583,000 in fiscal year 2020 and
 622.17 \$53,639,000 in fiscal year 2021.

622.18 **Subd. 20. Grant Programs; Child Care**
 622.19 **Development Grants**

1,737,000

1,737,000

622.20 **Subd. 21. Grant Programs; Child Support**
 622.21 **Enforcement Grants**

50,000

50,000

622.22 **Subd. 22. Grant Programs; Children's Services**
 622.23 **Grants**

622.24 Appropriations by Fund

622.25 General 39,240,000 39,165,000

622.26 Federal TANF 140,000 140,000

622.27 **(a) Title IV-E Adoption Assistance.** (1) The
 622.28 commissioner shall allocate funds from the
 622.29 Title IV-E reimbursement to the state from
 622.30 the Fostering Connections to Success and
 622.31 Increasing Adoptions Act for adoptive, foster,
 622.32 and kinship families as required in Minnesota
 622.33 Statutes, section 256N.261.

622.34 **(2) Additional federal reimbursement to the**
 622.35 **state as a result of the Fostering Connections**

623.1 to Success and Increasing Adoptions Act's
623.2 expanded eligibility for title IV-E adoption
623.3 assistance is for postadoption, foster care,
623.4 adoption, and kinship services, including a
623.5 parent-to-parent support network.

623.6 **(b) Adoption Assistance Incentive Grants.**

623.7 (1) The commissioner shall allocate federal
623.8 funds available for adoption and guardianship
623.9 assistance incentive grants for postadoption
623.10 services to support adoptive, foster, and
623.11 kinship families as required in Minnesota
623.12 Statutes, section 256N.261.

623.13 (2) Federal funds available during fiscal year
623.14 2019 for adoption incentive grants must be
623.15 used for foster care, adoption, and kinship
623.16 services, including a parent-to-parent support
623.17 network.

623.18 **(c) Adoption Support Services.** The
623.19 commissioner shall allocate 20 percent of
623.20 federal funds from title IV-B, subpart 2, of the
623.21 Social Security Act, Promoting Safe and
623.22 Stable Families, for adoption support services
623.23 under Minnesota Statutes, section 256N.261.

623.24 **(d) Anoka County Family Foster Care.**

623.25 \$75,000 in fiscal year 2018 is from the general
623.26 fund for a grant to Anoka County to establish
623.27 and promote family foster care recruitment
623.28 models. The county shall use the grant funds
623.29 for the purpose of increasing foster care
623.30 providers through administrative
623.31 simplification, nontraditional recruitment
623.32 models, and family incentive options, and
623.33 develop a strategic planning model to recruit
623.34 family foster care providers. This is a onetime
623.35 appropriation.

624.1 (e) White Earth Band of Ojibwe Child624.2 Welfare Services. \$500,000 in fiscal year624.3 2018 and \$500,000 in fiscal year 2019 are624.4 from the general fund for a grant to the White624.5 Earth Band of Ojibwe to deliver child welfare624.6 services.624.7 Subd. 23. Grant Programs; Children and624.8 Community Service Grants58,201,00058,201,000624.9 Subd. 24. Grant Programs; Children and624.10 Economic Support Grants32,930,00032,940,000624.11 (a) Minnesota Food Assistance Program.624.12 Unexpended funds for the Minnesota food624.13 assistance program for fiscal year 2018 do not624.14 cancel but are available for this purpose in624.15 fiscal year 2019.624.16 (b) Long-term Homeless Supportive624.17 Services. \$375,000 in fiscal year 2018 and624.18 \$375,000 in fiscal year 2019 are for the624.19 long-term homeless supportive services fund624.20 under Minnesota Statutes, section 256K.26.624.21 This is a onetime appropriation.624.22 (c) Community Action Grants. \$750,000 in624.23 fiscal year 2018 and \$750,000 in fiscal year624.24 2019 are for community action grants under624.25 Minnesota Statutes, sections 256E.30 to624.26 256E.32. This is a onetime appropriation.624.27 (d) Transitional Housing. \$200,000 in fiscal624.28 year 2018 and \$200,000 in fiscal year 2019624.29 are for the transitional housing program under624.30 Minnesota Statutes, section 256E.33. This is624.31 a onetime appropriation.624.32 (e) Family Assets for Independence.624.33 \$250,000 in fiscal year 2018 and \$250,000 in624.34 fiscal year 2019 are for the family assets for624.35 independence program under Minnesota

625.1 Statutes, section 256E.35. This is a onetime
625.2 appropriation.

625.3 **(f) Safe Harbor for Sexually Exploited**
625.4 **Youth.** (1) \$400,000 in fiscal year 2018 and
625.5 \$400,000 in fiscal year 2019 are for
625.6 emergency shelter and transitional and
625.7 long-term housing beds for sexually exploited
625.8 youth and youth at risk of sexual exploitation.

625.9 (2) \$100,000 in fiscal year 2018 and \$100,000
625.10 in fiscal year 2019 are for statewide youth
625.11 outreach workers connecting sexually
625.12 exploited youth and youth at risk of sexual
625.13 exploitation with shelter and services.

625.14 (3) Youth 24 years of age or younger are
625.15 eligible for shelter, housing beds, and services
625.16 under this paragraph. In funding shelter,
625.17 housing beds, and outreach workers under this
625.18 paragraph, the commissioner shall emphasize
625.19 activities that promote capacity-building and
625.20 development of resources in greater
625.21 Minnesota.

625.22 **(g) Emergency Services Program.** \$100,000
625.23 in fiscal year 2018 and \$100,000 in fiscal year
625.24 2019 are for the emergency services program,
625.25 which provides services and emergency shelter
625.26 for homeless Minnesotans under Minnesota
625.27 Statutes, section 256E.36. This is a onetime
625.28 appropriation.

625.29 **(h) Dakota County Child Data Tracking.**
625.30 \$200,000 in fiscal year 2018 is for the
625.31 Minnesota Birth to Eight pilot project for the
625.32 development of the information technology
625.33 solution that will track the established

626.1 developmental milestone progress of each
626.2 child participating in the pilot up to age eight.

626.3 **(i) Food Shelf Programs.** \$375,000 in fiscal
626.4 year 2018 and \$375,000 in fiscal year 2019
626.5 are for food shelf programs under Minnesota
626.6 Statutes, section 256E.34. This appropriation
626.7 may be used to purchase proteins, fruits,
626.8 vegetables, and diapers. This is a onetime
626.9 appropriation.

626.10 **(j) Community Living Infrastructure.**
626.11 \$1,400,000 in fiscal year 2018 and \$1,400,000
626.12 in fiscal year 2019 are for community living
626.13 infrastructure grant allocations under article
626.14 2, section 17.

626.15 **(k) Housing Web Site Grant.** \$150,000 in
626.16 fiscal year 2018 and \$150,000 in fiscal year
626.17 2019 are for a grant to a public or private
626.18 entity to create and maintain a Web site and
626.19 application to track real-time housing openings
626.20 for people with disabilities.

626.21 **(l) Housing Benefit Web Site.** \$130,000 in
626.22 fiscal year 2018 and \$130,000 in fiscal year
626.23 2019 are to operate the housing benefit 101
626.24 Web site to help people who need affordable
626.25 housing, and supports to maintain that
626.26 housing, understand the range of housing
626.27 options and support services available.

626.28 **(m) Coparenting Education.** \$150,000 in
626.29 fiscal year 2018 and \$150,000 in fiscal year
626.30 2019 are for a grant to a health and wellness
626.31 center located in North Minneapolis that is a
626.32 federally qualified health center. This is a
626.33 onetime appropriation. The center must use
626.34 the grant money to offer coparent services to

627.1 unmarried parents. The center must develop
627.2 a process to inform and educate unmarried
627.3 parents about the center's coparent services.
627.4 The coparent services must include the
627.5 following:
627.6 (1) coparenting workshops for the unmarried
627.7 parents;
627.8 (2) assistance to the unmarried parents in
627.9 developing a parenting plan that specifies a
627.10 schedule of the time each parent spends with
627.11 the child, child support obligations, and a
627.12 designation of decision-making responsibilities
627.13 regarding the child's education, medical needs,
627.14 and religious upbringing;
627.15 (3) an assessment of social services needs for
627.16 each parent; and
627.17 (4) additional social services support,
627.18 including support related to employment,
627.19 education, and housing.
627.20 The parenting plan assistance must include
627.21 the option of using private mediation.
627.22 The coparent workshops must focus at a
627.23 minimum on (i) the benefits to the child of
627.24 having both parents involved in a child's life,
627.25 (ii) promoting both parents' participation in a
627.26 child's life, (iii) building coparenting and
627.27 communication skills, (iv) information on
627.28 establishing paternity, (v) assisting parents in
627.29 developing a parenting plan, and (vi) educating
627.30 participants on how to foster a nonresident
627.31 parent's continued involvement in a child's
627.32 life.
627.33 (n) **Base Level Adjustments.** The general
627.34 fund base is \$30,840,000 in fiscal year 2020

628.1 and \$31,940,000 in fiscal year 2021. The
 628.2 general fund base includes \$453,000 in fiscal
 628.3 year 2020 and \$453,000 in fiscal year 2021
 628.4 for community living infrastructure grant
 628.5 allocations under Minnesota Statutes, section
 628.6 256I.09.

628.7 **Subd. 25. Grant Programs; Health Care Grants**

628.8	<u>Appropriations by Fund</u>		
628.9	<u>General</u>	<u>5,119,000</u>	<u>3,711,000</u>
628.10	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>

628.11 **Chronic Pain Rehabilitation Therapy**
 628.12 **Demonstration Project.** \$1,000,000 in fiscal
 628.13 year 2018 is from the general fund for a
 628.14 chronic pain rehabilitation therapy
 628.15 demonstration project with a rehabilitation
 628.16 institute. The commissioner may use up to
 628.17 three percent of this appropriation for
 628.18 administrative costs for the project. This is a
 628.19 onetime appropriation.

628.20	<u>Subd. 26. Grant Programs; Other Long-Term</u>		
628.21	<u>Care Grants</u>	<u>2,500,000</u>	<u>2,925,000</u>

628.22 **(a) Home and Community-Based Incentive**
 628.23 **Pool.** \$1,000,000 in fiscal year 2018 and
 628.24 \$1,000,000 in fiscal year 2019 are for
 628.25 incentive payments under Minnesota Statutes,
 628.26 section 256B.0921. This is a onetime
 628.27 appropriation.

628.28 **(b) Base Level Adjustment.** The general fund
 628.29 base is \$1,925,000 in fiscal year 2020 and
 628.30 \$1,925,000 in fiscal year 2021.

628.31	<u>Subd. 27. Grant Programs; Aging and Adult</u>		
628.32	<u>Services Grants</u>	<u>30,786,000</u>	<u>32,437,000</u>

628.33 **(a) Gap Analysis.** \$217,000 in fiscal year
 628.34 2018 and \$218,000 in fiscal year 2019 are for

629.1 analysis of gaps in long-term care services
 629.2 under Minnesota Statutes, section 144A.351.

629.3 **(b) Advanced In-Home Activity-Monitoring**
 629.4 **Systems.** \$40,000 in fiscal year 2018 is for a
 629.5 grant to a local research organization with
 629.6 expertise in identifying current and potential
 629.7 support systems and examining the capacity
 629.8 of those systems to meet the needs of the
 629.9 growing population of elderly persons to
 629.10 conduct a comprehensive assessment of
 629.11 current literature, past research, and an
 629.12 environmental scan of the field related to
 629.13 advanced in-home activity-monitoring systems
 629.14 for elderly persons. The commissioner must
 629.15 report the results of the assessment by January
 629.16 15, 2018, to the legislative committees and
 629.17 divisions with jurisdiction over health and
 629.18 human services policy and finance. This is a
 629.19 onetime appropriation.

629.20 **(c) Base Level Adjustments.** The general
 629.21 fund base is \$32,811,000 in fiscal year 2020
 629.22 and \$32,995,000 in fiscal year 2021. The
 629.23 general fund base includes \$334,000 in fiscal
 629.24 year 2020 and \$477,000 in fiscal year 2021
 629.25 for the Minnesota Board on Aging for
 629.26 self-directed caregiver grants under Minnesota
 629.27 Statutes, section 256.975, subdivision 12.

629.28 **Subd. 28. Grant Programs; Deaf and**
 629.29 **Hard-of-Hearing Grants**

2,675,000

2,675,000

629.30 **Expanded Services Grants.** \$800,000 in
 629.31 fiscal year 2018 and \$800,000 in fiscal year
 629.32 2019 are for deaf and hard-of-hearing grants.
 629.33 The funds must be used to:

629.34 (1) provide linguistically and culturally
 629.35 appropriate mental health services for children

630.1 who are deaf, children who are deafblind, and
 630.2 children who are hard-of-hearing in
 630.3 northwestern and northeastern Minnesota;
 630.4 (2) provide psychiatric services statewide for
 630.5 people who are deaf, people who are
 630.6 deafblind, and people who are hard-of-hearing;
 630.7 and

630.8 (3) provide services and assistive technology
 630.9 for people who are deafblind throughout
 630.10 Minnesota.

630.11	<u>Subd. 29. Grant Programs; Disabilities Grants</u>	<u>21,175,000</u>	<u>21,176,000</u>
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630.12 **(a) Disability Waiver Rate System**
 630.13 **Transition Grants.** \$30,000 in fiscal year
 630.14 2018 and \$31,000 in fiscal year 2019 are for
 630.15 grants to home and community-based
 630.16 disability waiver services providers that are
 630.17 projected to receive at least a ten percent
 630.18 decrease in revenues due to transition to rates
 630.19 calculated under Minnesota Statutes, section
 630.20 256B.4914. The commissioner shall award
 630.21 grants to ensure ongoing access for individuals
 630.22 currently receiving these services and provide
 630.23 stability to providers as they transition to new
 630.24 service delivery models. The general fund base
 630.25 for the grants under this paragraph is \$287,000
 630.26 in fiscal year 2020 and \$288,000 in fiscal year
 630.27 2021.

630.28 **(b) Self-Advocacy Grants.** \$133,000 in fiscal
 630.29 year 2018 and \$133,000 in fiscal year 2019
 630.30 are for grants under Minnesota Statutes,
 630.31 section 256.477, paragraph (a).

630.32 **(c) Services for Persons with Intellectual**
 630.33 **and Developmental Disabilities.** \$143,000
 630.34 in fiscal year 2018 and \$143,000 in fiscal year

631.1 2019 are for a grant to an organization
631.2 described under Minnesota Statutes, section
631.3 256.477. This is a onetime appropriation.
631.4 Grant funds must be used for the following
631.5 purposes:

631.6 (1) to maintain the infrastructure needed to
631.7 train and support the activities of a statewide
631.8 network of peer-to-peer mentors for persons
631.9 with developmental disabilities, focused on
631.10 building awareness of service options and
631.11 advocacy skills necessary to move toward full
631.12 inclusion in community life, including the
631.13 development and delivery of the curriculum
631.14 to support the peer-to-peer network;

631.15 (2) to provide outreach activities, including
631.16 statewide conferences and disability
631.17 networking opportunities focused on
631.18 self-advocacy, informed choice, and
631.19 community engagement skills;

631.20 (3) to provide an annual leadership program
631.21 for persons with intellectual and
631.22 developmental disabilities; and

631.23 (4) to provide for administrative and general
631.24 operating costs associated with managing and
631.25 maintaining facilities, program delivery,
631.26 evaluation, staff, and technology.

631.27 **(d) Outreach to Persons in Institutional**
631.28 **Settings.** \$105,000 in fiscal year 2018 and
631.29 \$105,000 in fiscal year 2019 are for a grant to
631.30 an organization described under Minnesota
631.31 Statutes, section 256.477, to be used for
631.32 subgrants to organizations in Minnesota to
631.33 conduct outreach to persons working and
631.34 living in institutional settings to provide

632.1 education and information about community
632.2 options. This is a onetime appropriation. Grant
632.3 funds must be used to deliver peer-led skill
632.4 training sessions in six regions of the state to
632.5 help persons with intellectual and
632.6 developmental disabilities understand
632.7 community service options related to:
632.8 (1) housing;
632.9 (2) employment;
632.10 (3) education;
632.11 (4) transportation;
632.12 (5) emerging service reform initiatives
632.13 contained in the state's Olmstead plan; the
632.14 Workforce Innovation and Opportunity Act,
632.15 Public Law 113-128; and federal home and
632.16 community-based services regulations; and
632.17 (6) connecting with individuals who can help
632.18 persons with intellectual and developmental
632.19 disabilities make an informed choice and plan
632.20 for a transition in services.
632.21 **(e) Community Living Grants.** To the extent
632.22 funding is available, the commissioner may
632.23 transfer funds from the semi-independent
632.24 living services grant to new community living
632.25 grants to pay for transitional costs and
632.26 facilitate the transition of individuals from
632.27 corporate foster care to community living.
632.28 **(f) Life Skills Training for Individuals with**
632.29 **Autism Spectrum Disorder.** \$125,000 in
632.30 fiscal year 2018 and \$125,000 in fiscal year
632.31 2019 are for a grant to an organization located
632.32 in Richfield that provides life skills training
632.33 to young adults with learning disabilities to

633.1 meet the needs of individuals with autism
 633.2 spectrum disorder. This is a onetime
 633.3 appropriation. This appropriation may be used
 633.4 to:
 633.5 (1) create a best practices curriculum for
 633.6 servicing individuals with autism spectrum
 633.7 disorder in residential placements with
 633.8 therapeutic programming; and
 633.9 (2) expand facilities by adding safety features,
 633.10 living spaces, and academic areas.

633.11 (g) **Base Level Adjustment.** The general fund
 633.12 base is \$21,059,000 in fiscal year 2020 and
 633.13 \$21,060,000 in fiscal year 2021.

633.14 Subd. 30. **Grant Programs; Adult Mental Health**
 633.15 **Grants**

633.16	<u>Appropriations by Fund</u>		
633.17	<u>General</u>	<u>81,577,000</u>	<u>81,477,000</u>
633.18	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>

633.19 (a) **Peer-Run Respite Services in Wadena**
 633.20 **County.** \$100,000 in fiscal year 2018 is from
 633.21 the general fund for a grant to Wadena County
 633.22 for the planning and development of a peer-run
 633.23 respite center for individuals experiencing
 633.24 mental health conditions or co-occurring
 633.25 substance abuse disorder. This is a onetime
 633.26 appropriation and is available until June 30,
 633.27 2021. The grant is contingent on Wadena
 633.28 County providing to the commissioner of
 633.29 human services a plan to fund, operate, and
 633.30 sustain the program and services after the
 633.31 onetime state grant is expended. Wadena
 633.32 County must outline the proposed funding
 633.33 stream or mechanism, and any necessary local
 633.34 funding commitment, which will ensure the
 633.35 program will result in a sustainable program.

634.1 The funding stream may include state funding
634.2 for programs and services for which the
634.3 individuals served under this paragraph may
634.4 be eligible. The commissioner of human
634.5 services, in collaboration with Wadena
634.6 County, may explore a plan for continued
634.7 funding using existing appropriations through
634.8 eligibility for group residential housing under
634.9 Minnesota Statutes, chapter 256I.

634.10 The peer-run respite center must:

634.11 (1) admit individuals who are in need of peer
634.12 support and supportive services while
634.13 addressing an increase in symptoms or
634.14 stressors or exacerbation of their mental health
634.15 or substance abuse;

634.16 (2) admit individuals to reside at the center on
634.17 a short-term basis, no longer than five days;

634.18 (3) be operated by a nonprofit organization;

634.19 (4) employ individuals who have personal
634.20 experience with mental health or co-occurring
634.21 substance abuse conditions who meet the
634.22 qualifications of a mental health certified peer
634.23 specialist under Minnesota Statutes, section
634.24 256B.0615, or a recovery peer;

634.25 (5) provide at least three but no more than six
634.26 beds in private rooms; and

634.27 (6) not provide clinical services.

634.28 By November 1, 2018, the commissioner of
634.29 human services, in consultation with Wadena
634.30 County, shall report to the committees in the
634.31 senate and house of representatives with
634.32 jurisdiction over mental health issues, the
634.33 status of planning and development of the

635.1 peer-run respite center, and the plan to
635.2 financially support the program and services
635.3 after the state grant is expended.

635.4 **(b) Housing Options for Persons with**
635.5 **Serious Mental Illness. \$575,000 in fiscal**
635.6 **year 2018 and \$575,000 in fiscal year 2019**
635.7 **are from the general fund for adult mental**
635.8 **health grants under Minnesota Statutes, section**
635.9 **245.4661, subdivision 9, paragraph (a), clause**
635.10 **(2), to support increased availability of**
635.11 **housing options with supports for persons with**
635.12 **serious mental illness. This is a onetime**
635.13 **appropriation.**

635.14 **(c) Assertive Community Treatment.**
635.15 **\$200,000 in fiscal year 2018 and \$200,000 in**
635.16 **fiscal year 2019 are from the general fund for**
635.17 **adult mental health grants under Minnesota**
635.18 **Statutes, section 256B.0622, subdivision 12,**
635.19 **to expand assertive community treatment**
635.20 **services. This is a onetime appropriation.**

635.21 **(d) Mental Health Crisis Services. \$400,000**
635.22 **in fiscal year 2018 and \$400,000 in fiscal year**
635.23 **2019 are from the general fund for adult**
635.24 **mental health grants under Minnesota Statutes,**
635.25 **section 245.4661, and children's mental health**
635.26 **grants under Minnesota Statutes, section**
635.27 **245.4889, to expand mental health crisis**
635.28 **services, including:**

635.29 **(1) mobile crisis services;**

635.30 **(2) residential crisis services;**

635.31 **(3) colocation of mobile crisis services in**
635.32 **urgent care clinics and psychiatric emergency**
635.33 **departments; and**

636.1 (4) development of co-responder mental health
636.2 crisis response models.

636.3 This is a onetime appropriation.

636.4 (e) **Housing with Supports.** \$500,000 in fiscal
636.5 year 2018 and \$500,000 in fiscal year 2019
636.6 are for the housing with supports for adults
636.7 with serious mental illness grant under
636.8 Minnesota Statutes, section 245.4661,
636.9 subdivision 9, paragraph (a), clause (2). This
636.10 is a onetime appropriation.

636.11 (f) **Base Level Adjustment.** The general fund
636.12 base is \$79,802,000 in fiscal year 2020 and
636.13 \$79,802,000 in fiscal year 2021.

636.14 Subd. 31. **Grant Programs; Child Mental Health**
636.15 **Grants**

21,411,000

21,476,000

636.16 (a) **First Psychotic Episode Funding.**
636.17 \$500,000 in fiscal year 2018 and \$500,000 in
636.18 fiscal year 2019 are for grants under
636.19 Minnesota Statutes, section 245.4889,
636.20 subdivision 1, paragraph (b), clause (15). This
636.21 is a onetime appropriation. Funding shall be
636.22 used to:

636.23 (1) provide intensive treatment and supports
636.24 to adolescents and adults experiencing or at
636.25 risk of a first psychotic episode. Intensive
636.26 treatment and support includes medication
636.27 management, psychoeducation for the
636.28 individual and family, case management,
636.29 employment supports, education supports,
636.30 cognitive behavioral approaches, social skills
636.31 training, peer support, crisis planning, and
636.32 stress management. Projects must use all
636.33 available funding streams;

637.1 (2) conduct outreach, training, and guidance
 637.2 to mental health and health care professionals,
 637.3 including postsecondary health clinics, on
 637.4 early psychosis symptoms, screening tools,
 637.5 and best practices; and

637.6 (3) ensure access to first psychotic episode
 637.7 psychosis services under this section,
 637.8 including ensuring access for individuals who
 637.9 live in rural areas. Funds may be used to pay
 637.10 for housing or travel or to address other
 637.11 barriers to individuals and their families
 637.12 participating in first psychotic episode
 637.13 services.

637.14 **(b) Respite Care Services.** \$150,000 in fiscal
 637.15 year 2018 and \$150,000 in fiscal year 2019
 637.16 are for children's mental health grants under
 637.17 Minnesota Statutes, section 245.4889,
 637.18 subdivision 1, paragraph (b), clause (3), to
 637.19 provide respite care services to families of
 637.20 children with serious mental illness. This is a
 637.21 onetime appropriation.

637.22 **(c) Base Level Adjustment.** The general fund
 637.23 base is \$20,826,000 in fiscal year 2020 and
 637.24 \$20,826,000 in fiscal year 2021.

637.25 Subd. 32. **Grant Programs; Chemical**
 637.26 **Dependency Treatment Support Grants**

637.27	<u>Appropriations by Fund</u>	
637.28	<u>General</u>	<u>2,386,000</u> <u>2,386,000</u>
637.29	<u>Lottery Prize</u>	<u>1,733,000</u> <u>1,733,000</u>

637.30 **(a) Minnesota Transitions Charter School.**
 637.31 Notwithstanding any other law to the contrary,
 637.32 Minnesota Transitions Charter School is
 637.33 eligible to receive grants under Minnesota
 637.34 Statutes, section 254A.03, subdivision 1.

638.1 (b) **Problem Gambling.** \$225,000 in fiscal
638.2 year 2018 and \$225,000 in fiscal year 2019
638.3 are from the lottery prize fund for a grant to
638.4 the state affiliate recognized by the National
638.5 Council on Problem Gambling. The affiliate
638.6 must provide services to increase public
638.7 awareness of problem gambling, education,
638.8 and training for individuals and organizations
638.9 providing effective treatment services to
638.10 problem gamblers and their families, and
638.11 research related to problem gambling.

638.12 (c) **Minnesota Organization on Fetal**
638.13 **Alcohol Syndrome.** \$250,000 in fiscal year
638.14 2018 and \$250,000 in fiscal year 2019 are for
638.15 a grant to the Minnesota Organization on Fetal
638.16 Alcohol Syndrome (MOFAS). This is a
638.17 onetime appropriation. Of this amount,
638.18 MOFAS shall make grants to eligible regional
638.19 collaboratives that fulfill the requirements in
638.20 this paragraph. "Eligible regional
638.21 collaboratives" means a partnership between
638.22 at least one local government and at least one
638.23 community-based organization and, where
638.24 available, a family home visiting program. For
638.25 purposes of this paragraph, a local government
638.26 includes a county or multicounty organization,
638.27 a tribal government, a county-based
638.28 purchasing entity, or a community health
638.29 board. Eligible regional collaboratives must
638.30 use grant funds to reduce the incidence of fetal
638.31 alcohol syndrome disorders and other prenatal
638.32 drug-related effects in children in Minnesota
638.33 by identifying and serving pregnant women
638.34 suspected of or known to use or abuse alcohol
638.35 or other drugs. The eligible regional
638.36 collaboratives must provide intensive services

639.1 to chemically dependent women to increase
 639.2 positive birth outcomes. MOFAS must make
 639.3 grants to eligible regional collaboratives from
 639.4 both rural and urban areas. A grant recipient
 639.5 must report to the commissioner of human
 639.6 services annually by January 15 on the
 639.7 services and programs funded by the
 639.8 appropriation. The report must include
 639.9 measurable outcomes for the previous year,
 639.10 including the number of pregnant women
 639.11 served and the number of toxic-free babies
 639.12 born.

639.13 (d) **Base Level Adjustment.** The general fund
 639.14 base is \$2,136,000 in fiscal year 2020 and
 639.15 \$2,136,000 in fiscal year 2021.

639.16 Subd. 33. **Direct Care and Treatment - Generally**

639.17 (a) **Transfer Authority.** Money appropriated
 639.18 to budget activities under subdivisions 34, 35,
 639.19 36, 37, and 38 may be transferred between
 639.20 budget activities and between years of the
 639.21 biennium with the approval of the
 639.22 commissioner of management and budget.

639.23 (b) **Dedicated Receipts Available.** Of the
 639.24 revenue received under Minnesota Statutes,
 639.25 section 246.18, subdivision 8, paragraph (a),
 639.26 up to \$1,000,000 each year is available for the
 639.27 purposes of Minnesota Statutes, section
 639.28 246.18, subdivision 8, paragraph (b), clause
 639.29 (1); and up to \$2,713,000 each year is
 639.30 available for the purposes of Minnesota
 639.31 Statutes, section 246.18, subdivision 8,
 639.32 paragraph (b), clause (2).

639.33 Subd. 34. **Direct Care and Treatment - Mental**
 639.34 **Health and Substance Abuse**

118,545,000

118,631,000

640.1 **(a) Child and Adolescent Behavioral Health**
 640.2 **Services.** \$405,000 in fiscal year 2018 and
 640.3 \$491,000 in fiscal year 2019 are to continue
 640.4 to operate the child and adolescent behavioral
 640.5 health services program under Minnesota
 640.6 Statutes, section 246.014. This is a onetime
 640.7 appropriation.

640.8 **(b) DCT Operating Adjustment (CARE).**
 640.9 \$447,000 in fiscal year 2018 and \$447,000 in
 640.10 fiscal year 2019 are for Community Addiction
 640.11 Recovery Enterprise (CARE) operating
 640.12 adjustments. The commissioner must transfer
 640.13 \$447,000 in fiscal year 2018 and \$447,000 in
 640.14 fiscal year 2019 to the enterprise fund for
 640.15 CARE.

640.16 **(c) Base Level Adjustment.** The general fund
 640.17 base is \$118,140,000 in fiscal year 2020 and
 640.18 \$118,140,000 in fiscal year 2021.

640.19 **Subd. 35. Direct Care and Treatment -**
 640.20 **Community-Based Services**

25,652,000

20,543,000

640.21 **(a) DCT Operating Adjustment (MSOCS).**
 640.22 \$2,393,000 in fiscal year 2018 and \$2,393,000
 640.23 in fiscal year 2019 are for Minnesota State
 640.24 Operated Community Services (MSOCS)
 640.25 operating adjustments. The commissioner must
 640.26 transfer \$2,393,000 in fiscal year 2018 and
 640.27 \$2,393,000 in fiscal year 2019 to the enterprise
 640.28 fund for MSOCS.

640.29 **(b) MSOCS Sustainability.** \$7,697,000 in
 640.30 fiscal year 2018 and \$2,588,000 in fiscal year
 640.31 2019 are for the Minnesota State Operated
 640.32 Community Services program. Of this amount,
 640.33 the commissioner must transfer \$6,697,000 in
 640.34 fiscal year 2018 and \$1,588,000 in fiscal year
 640.35 2019 to the enterprise fund for Minnesota State

641.1	<u>Operated Community Services. \$1,000,000 is</u>		
641.2	<u>available each year of the biennium for</u>		
641.3	<u>start-up expenses for new residential homes</u>		
641.4	<u>to be operated by Minnesota State Operated</u>		
641.5	<u>Community Services.</u>		
641.6	<u>(c) Base Level Adjustment.</u> The general fund		
641.7	<u>base is \$18,955,000 in fiscal year 2021.</u>		
641.8	<u>Subd. 36. Direct Care and Treatment - Forensic</u>		
641.9	<u>Services</u>	<u>102,806,000</u>	<u>106,958,000</u>
641.10	<u>Base Level Adjustment.</u> The general fund		
641.11	<u>base in fiscal year 2020 is \$109,828,000 and</u>		
641.12	<u>\$112,437,000 in fiscal year 2021.</u>		
641.13	<u>Subd. 37. Direct Care and Treatment - Sex</u>		
641.14	<u>Offender Program</u>	<u>89,217,000</u>	<u>89,225,000</u>
641.15	<u>Transfer Authority.</u> Money appropriated for		
641.16	<u>the Minnesota sex offender program may be</u>		
641.17	<u>transferred between fiscal years of the</u>		
641.18	<u>biennium with the approval of the</u>		
641.19	<u>commissioner of management and budget.</u>		
641.20	<u>Subd. 38. Direct Care and Treatment -</u>		
641.21	<u>Operations</u>	<u>45,151,000</u>	<u>45,708,000</u>
641.22	<u>Base Level Adjustment.</u> The general fund		
641.23	<u>base is \$45,995,000 in fiscal year 2020 and</u>		
641.24	<u>\$46,256,000 in fiscal year 2021.</u>		
641.25	<u>Subd. 39. Technical Activities</u>	<u>86,186,000</u>	<u>86,339,000</u>
641.26	<u>(a) This appropriation is from the federal</u>		
641.27	<u>TANF fund.</u>		
641.28	<u>(b) Base Level Adjustment.</u> The TANF fund		
641.29	<u>base is \$86,346,000 in fiscal year 2020 and</u>		
641.30	<u>\$86,355,000 in fiscal year 2021.</u>		
641.31	Sec. 3. <u>COMMISSIONER OF HEALTH</u>		
641.32	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 213,792,000</u>	<u>\$ 207,347,000</u>
641.33	<u>Appropriations by Fund</u>		

	<u>2018</u>	<u>2019</u>
642.1		
642.2	<u>111,829,000</u>	<u>105,274,000</u>
642.3		
642.4	<u>53,607,000</u>	<u>54,102,000</u>
642.5	<u>36,643,000</u>	<u>36,258,000</u>
642.6	<u>11,713,000</u>	<u>11,713,000</u>

642.7 The amounts that may be spent for each
 642.8 purpose are specified in the following
 642.9 subdivisions.

642.10 Subd. 2. **Health Improvement**

	<u>Appropriations by Fund</u>	
642.11		
642.12	<u>81,438,000</u>	<u>78,100,000</u>
642.13		
642.14	<u>6,215,000</u>	<u>6,182,000</u>
642.15	<u>36,643,000</u>	<u>36,258,000</u>
642.16	<u>11,713,000</u>	<u>11,713,000</u>

642.17 (a) **TANF Appropriations.** (1) \$3,579,000
 642.18 of the TANF fund each year is for home
 642.19 visiting and nutritional services listed under
 642.20 Minnesota Statutes, section 145.882,
 642.21 subdivision 7, clauses (6) and (7). Funds must
 642.22 be distributed to community health boards
 642.23 according to Minnesota Statutes, section
 642.24 145A.131, subdivision 1.

642.25 (2) \$2,000,000 of the TANF fund each year
 642.26 is for decreasing racial and ethnic disparities
 642.27 in infant mortality rates under Minnesota
 642.28 Statutes, section 145.928, subdivision 7.

642.29 (3) \$4,978,000 of the TANF fund each year
 642.30 is for the family home visiting grant program
 642.31 according to Minnesota Statutes, section
 642.32 145A.17. \$4,000,000 of the funding must be
 642.33 distributed to community health boards
 642.34 according to Minnesota Statutes, section
 642.35 145A.131, subdivision 1. \$978,000 of the
 642.36 funding must be distributed to tribal

643.1 governments according to Minnesota Statutes,
643.2 section 145A.14, subdivision 2a.

643.3 (4) \$1,156,000 of the TANF fund each year
643.4 is for family planning grants under Minnesota
643.5 Statutes, section 145.925.

643.6 (5) The commissioner may use up to 6.23
643.7 percent of the funds appropriated each year to
643.8 conduct the ongoing evaluations required
643.9 under Minnesota Statutes, section 145A.17,
643.10 subdivision 7, and training and technical
643.11 assistance as required under Minnesota
643.12 Statutes, section 145A.17, subdivisions 4 and
643.13 5.

643.14 (b) TANF Carryforward. Any unexpended
643.15 balance of the TANF appropriation in the first
643.16 year of the biennium does not cancel but is
643.17 available for the second year.

643.18 (c) Evidence-Based Home Visiting.
643.19 \$6,000,000 in fiscal year 2018 and \$6,000,000
643.20 in fiscal year 2019 are from the general fund
643.21 to start up or expand evidence-based home
643.22 visiting programs. The commissioner shall
643.23 award grants to community health boards,
643.24 nonprofits, or tribal nations in urban and rural
643.25 areas of the state. Grant funds must be used
643.26 to start up or expand evidence-based home
643.27 visiting programs in the county, reservation,
643.28 or region to serve families, such as parents
643.29 with high risk or high needs, parents with a
643.30 history of mental illness, domestic abuse, or
643.31 substance abuse, or first-time mothers
643.32 prenatally until the child is four years of age,
643.33 who are eligible for medical assistance under
643.34 Minnesota Statutes, chapter 256B, or the
643.35 federal Special Supplemental Nutrition

644.1 Program for Women, Infants, and Children.
644.2 Priority for grants to rural areas shall be given
644.3 to community health boards, nonprofits, and
644.4 tribal nations that expand services within
644.5 regional partnerships that provide the
644.6 evidence-based home visiting programs. This
644.7 funding shall only be used to supplement, not
644.8 to replace, funds being used for
644.9 evidence-based home visiting services as of
644.10 June 30, 2017. Up to seven percent of the
644.11 appropriation may be used for training,
644.12 technical assistance, evaluation, and other
644.13 costs to administer the grants. The general
644.14 fund base for this program is \$16,500,000 in
644.15 fiscal year 2020 and \$16,500,000 in fiscal year
644.16 2021.

644.17 **(d) Safe Harbor for Sexually Exploited**
644.18 **Youth Services.** \$250,000 in fiscal year 2018
644.19 and \$250,000 in fiscal year 2019 are from the
644.20 general fund for trauma-informed, culturally
644.21 specific services for sexually exploited youth.
644.22 Youth 24 years of age or younger are eligible
644.23 for services under this paragraph.

644.24 **(e) Safe Harbor Program Technical**
644.25 **Assistance and Evaluation.** \$200,000 in
644.26 fiscal year 2018 and \$200,000 in fiscal year
644.27 2019 are from the general fund for training,
644.28 technical assistance, protocol implementation,
644.29 and evaluation activities related to the safe
644.30 harbor program. Of these amounts:
644.31 (1) \$90,000 each fiscal year is for providing
644.32 training and technical assistance to individuals
644.33 and organizations that provide safe harbor
644.34 services and receive funds for that purpose

645.1 from the commissioner of human services or
645.2 commissioner of health;

645.3 (2) \$90,000 each fiscal year is for protocol
645.4 implementation, which includes providing
645.5 technical assistance in establishing best
645.6 practices-based systems for effectively
645.7 identifying, interacting with, and referring
645.8 sexually exploited youth to appropriate
645.9 resources; and

645.10 (3) \$20,000 each fiscal year is for program
645.11 evaluation activities in compliance with
645.12 Minnesota Statutes, section 145.4718.

645.13 **(f) Promoting Safe Harbor Capacity. In**
645.14 **funding services and activities under**
645.15 **paragraphs (d) and (e), the commissioner shall**
645.16 **emphasize activities that promote**
645.17 **capacity-building and development of**
645.18 **resources in greater Minnesota.**

645.19 **(g) Administration of Safe Harbor**
645.20 **Program. \$60,000 in fiscal year 2018 and**
645.21 **\$60,000 in fiscal year 2019 are for**
645.22 **administration of the safe harbor for sexually**
645.23 **exploited youth program.**

645.24 **(h) Palliative Care Advisory Council.**
645.25 **\$44,000 in fiscal year 2018 and \$44,000 in**
645.26 **fiscal year 2019 are from the general fund for**
645.27 **the Palliative Care Advisory Council under**
645.28 **Minnesota Statutes, section 144.059. This is**
645.29 **a onetime appropriation.**

645.30 **(i) Transfer; Minnesota Biomedicine and**
645.31 **Bioethics Innovation Grants. \$2,500,000 in**
645.32 **fiscal year 2018 is from the general fund for**
645.33 **transfer to the Board of Regents of the**
645.34 **University of Minnesota for Minnesota**

646.1 biomedicine and bioethics innovation grants
646.2 under Minnesota Statutes, section 137.67. The
646.3 full amount of the appropriation is for grants,
646.4 and the University of Minnesota shall not use
646.5 any portion for administrative or monitoring
646.6 expenses. The steering committee of the
646.7 University of Minnesota and Mayo Foundation
646.8 partnership must submit a preliminary report
646.9 by April 1, 2018, and a final report by April
646.10 1, 2019, on all grant activities funded under
646.11 Minnesota Statutes, section 137.67, to the
646.12 chairs and ranking minority members of the
646.13 legislative committees with jurisdiction over
646.14 health and human services finance. This is a
646.15 onetime appropriation and is available until
646.16 June 30, 2021.

646.17 **(j) Statewide Strategic Plan for Victims of**
646.18 **Sex Trafficking.** \$73,000 in fiscal year 2018
646.19 is from the general fund for the development
646.20 of a comprehensive statewide strategic plan
646.21 and report to address the needs of sex
646.22 trafficking victims statewide. This is a onetime
646.23 appropriation.

646.24 **(k) Home and Community-Based Services**
646.25 **Employee Scholarship Program.** \$500,000
646.26 in fiscal year 2018 and \$500,000 in fiscal year
646.27 2019 are from the general fund for the home
646.28 and community-based services employee
646.29 scholarship program under Minnesota Statutes,
646.30 section 144.1503.

646.31 **(l) Comprehensive Advanced Life Support**
646.32 **Educational Program.** \$100,000 in fiscal
646.33 year 2018 and \$100,000 in fiscal year 2019
646.34 are from the general fund for the
646.35 comprehensive advanced life support

647.1 educational program under Minnesota Statutes,
647.2 section 144.6062. This is a onetime
647.3 appropriation.

647.4 **(m) Opioid Abuse Prevention. \$1,028,000**
647.5 in fiscal year 2018 is to establish and evaluate
647.6 accountable community for health opioid
647.7 abuse prevention pilot projects. \$28,000 of
647.8 this amount is for administration. This is a
647.9 onetime appropriation and is available until
647.10 June 30, 2021.

647.11 **(n) Advanced Care Planning. \$250,000 in**
647.12 fiscal year 2018 and \$250,000 in fiscal year
647.13 2019 are from the general fund for a grant to
647.14 a statewide advanced care planning resource
647.15 organization that has expertise in convening
647.16 and coordinating community-based strategies
647.17 to encourage individuals, families, caregivers,
647.18 and health care providers to begin
647.19 conversations regarding end-of-life care
647.20 choices that express an individual's health care
647.21 values and preferences and are based on
647.22 informed health care decisions. Of this
647.23 amount, \$9,000 each year is for administration.
647.24 This is a onetime appropriation.

647.25 **(o) Health Professionals Clinical Training**
647.26 **Expansion Grant Program. \$526,000 in**
647.27 fiscal year 2018 and \$526,000 in fiscal year
647.28 2019 are from the general fund for the primary
647.29 care and mental health professions clinical
647.30 training expansion grant program under
647.31 Minnesota Statutes, section 144.1505. Of this
647.32 amount, \$26,000 each year is for
647.33 administration.

647.34 **(p) Federally Qualified Health Centers.**
647.35 \$500,000 in fiscal year 2018 and \$500,000 in

648.1 fiscal year 2019 are from the general fund to
 648.2 provide subsidies to federally qualified health
 648.3 centers under Minnesota Statutes, section
 648.4 145.9269. This is a onetime appropriation.

648.5 (q) **Base Level Adjustments.** The general
 648.6 fund base is \$87,656,000 in fiscal year 2020
 648.7 and \$87,706,000 in fiscal year 2021. The
 648.8 health care access fund base is \$36,858,000
 648.9 in fiscal year 2020 and \$36,258,000 in fiscal
 648.10 year 2021.

648.11 Subd. 3. **Health Protection**

648.12	<u>Appropriations by Fund</u>	
648.13	<u>General</u>	<u>20,928,000</u> <u>17,339,000</u>
648.14	<u>State Government</u>	
648.15	<u>Special Revenue</u>	<u>47,392,000</u> <u>47,920,000</u>

648.16 (a) **Prescribed Pediatric Extended Care**
 648.17 **Center Licensure Activities.** \$64,000 in fiscal
 648.18 year 2018 and \$17,000 in fiscal year 2019 are
 648.19 from the state government special revenue
 648.20 fund for licensure of prescribed pediatric
 648.21 extended care centers under Minnesota
 648.22 Statutes, chapter 144H.

648.23 (b) **Vulnerable Adults in Health Care**
 648.24 **Settings.** \$1,162,000 in fiscal year 2018 and
 648.25 \$2,030,000 in fiscal year 2019 are from the
 648.26 general fund for regulating health care and
 648.27 home care settings. The general fund base for
 648.28 this purpose is \$2,401,000 in fiscal year 2020
 648.29 and \$3,405,000 in fiscal year 2021.

648.30 (c) **Transfer; Public Health Response**
 648.31 **Contingency Account.** The commissioner
 648.32 shall transfer \$5,000,000 in fiscal year 2018
 648.33 from the general fund to the public health
 648.34 response contingency account established in
 648.35 Minnesota Statutes, section 144.4199.

649.1	<u>(d) Base Level Adjustment.</u> The general fund		
649.2	base is \$17,710,000 in fiscal year 2020 and		
649.3	\$18,714,000 in fiscal year 2021. The state		
649.4	government special revenue fund base is		
649.5	\$47,958,000 in fiscal year 2020 and		
649.6	\$48,295,000 in fiscal year 2021.		
649.7	Subd. 4. Health Operations	<u>9,463,000</u>	<u>9,835,000</u>
649.8	Sec. 4. HEALTH-RELATED BOARDS		
649.9	Subdivision 1. Total Appropriation	\$ 25,002,000	\$ 23,295,000
649.10	This appropriation is from the state		
649.11	government special revenue fund. The		
649.12	amounts that may be spent for each purpose		
649.13	are specified in the following subdivisions.		
649.14	Subd. 2. Board of Chiropractic Examiners	<u>565,000</u>	<u>571,000</u>
649.15	Base Level Adjustment. The base is \$576,000		
649.16	in fiscal year 2020 and \$576,000 in fiscal year		
649.17	2021.		
649.18	Subd. 3. Board of Dentistry	<u>1,396,000</u>	<u>1,408,000</u>
649.19	Subd. 4. Board of Dietetics and Nutrition		
649.20	Practice	<u>130,000</u>	<u>132,000</u>
649.21	Subd. 5. Board of Marriage and Family Therapy	<u>360,000</u>	<u>357,000</u>
649.22	Base Level Adjustment. The base is \$360,000		
649.23	in fiscal year 2020 and \$361,000 in fiscal year		
649.24	2021.		
649.25	Subd. 6. Board of Medical Practice	<u>5,193,000</u>	<u>5,329,000</u>
649.26	(a) Health Professional Services Program.		
649.27	This appropriation includes \$955,000 in fiscal		
649.28	year 2018 and \$964,000 in fiscal year 2019		
649.29	for the health professional services program.		
649.30	The base for this program is \$924,000 in fiscal		
649.31	year 2020 and \$924,000 in fiscal year 2021.		

650.1 (b) Base Level Adjustment. The base is
 650.2 \$5,291,000 in fiscal year 2020 and \$5,291,000
 650.3 in fiscal year 2021.

650.4 <u>Subd. 7. Board of Nursing</u>	<u>6,380,000</u>	<u>4,783,000</u>
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650.5 <u>Subd. 8. Board of Nursing Home Administrators</u>	<u>3,397,000</u>	<u>3,202,000</u>
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650.6 (a) Administrative Services Unit - Operating
 650.7 Costs. Of this appropriation, \$2,260,000 in
 650.8 fiscal year 2018 and \$2,287,000 in fiscal year
 650.9 2019 are for operating costs of the
 650.10 administrative services unit. The
 650.11 administrative services unit may receive and
 650.12 expend reimbursements for services it
 650.13 performs for other agencies.

650.14 (b) Administrative Services Unit - Volunteer
 650.15 Health Care Provider Program. Of this
 650.16 appropriation, \$150,000 in fiscal year 2018
 650.17 and \$150,000 in fiscal year 2019 are to pay
 650.18 for medical professional liability coverage
 650.19 required under Minnesota Statutes, section
 650.20 214.40.

650.21 (c) Administrative Services Unit -
 650.22 Retirement Costs. Of this appropriation,
 650.23 \$378,000 in fiscal year 2018 is a onetime
 650.24 appropriation to the administrative services
 650.25 unit to pay for the retirement costs of
 650.26 health-related board employees. This funding
 650.27 may be transferred to the health board
 650.28 incurring retirement costs. Any board that has
 650.29 an unexpended balance for an amount
 650.30 transferred under this paragraph shall transfer
 650.31 the unexpended amount to the administrative
 650.32 services unit. These funds are available either
 650.33 year of the biennium.

651.1 **(d) Administrative Services Unit -**
 651.2 **Health-Related Licensing Boards Operating**
 651.3 **Costs.** Of this appropriation, \$194,000 in
 651.4 fiscal year 2018 and \$350,000 in fiscal year
 651.5 2019 shall be transferred to the health-related
 651.6 boards funded under this section for operating
 651.7 costs. The administrative services unit shall
 651.8 determine transfer amounts in consultation
 651.9 with the health-related boards funded under
 651.10 this section.

651.11 **(e) Administrative Services Unit - Contested**
 651.12 **Cases and Other Legal Proceedings.** Of this
 651.13 appropriation, \$200,000 in fiscal year 2018
 651.14 and \$200,000 in fiscal year 2019 are for costs
 651.15 of contested case hearings and other
 651.16 unanticipated costs of legal proceedings
 651.17 involving health-related boards funded under
 651.18 this section. Upon certification by a
 651.19 health-related board to the administrative
 651.20 services unit that costs will be incurred and
 651.21 that there is insufficient money available to
 651.22 pay for the costs out of money currently
 651.23 available to that board, the administrative
 651.24 services unit is authorized to transfer money
 651.25 from this appropriation to the board for
 651.26 payment of those costs with the approval of
 651.27 the commissioner of management and budget.
 651.28 The commissioner of management and budget
 651.29 must require any board that has an unexpended
 651.30 balance for an amount transferred under this
 651.31 paragraph to transfer the unexpended amount
 651.32 to the administrative services unit to be
 651.33 deposited in the state government special
 651.34 revenue fund.

651.35 **Subd. 9. Board of Optometry** 173,000 174,000

652.1	<u>Subd. 10. Board of Pharmacy</u>	<u>3,124,000</u>	<u>3,164,000</u>
652.2	<u>Base Level Adjustment.</u> The base is		
652.3	<u>\$3,189,000 in fiscal year 2020 and \$3,226,000</u>		
652.4	<u>in fiscal year 2021.</u>		
652.5	<u>Subd. 11. Board of Physical Therapy</u>	<u>521,000</u>	<u>522,000</u>
652.6	<u>Base Level Adjustment.</u> The base is \$524,000		
652.7	<u>in fiscal year 2020 and \$526,000 in fiscal year</u>		
652.8	<u>2021.</u>		
652.9	<u>Subd. 12. Board of Podiatric Medicine</u>	<u>204,000</u>	<u>204,000</u>
652.10	<u>Subd. 13. Board of Psychology</u>	<u>1,220,000</u>	<u>1,240,000</u>
652.11	<u>Base Level Adjustment.</u> The base is		
652.12	<u>\$1,247,000 in fiscal year 2020 and \$1,247,000</u>		
652.13	<u>in fiscal year 2021.</u>		
652.14	<u>Subd. 14. Board of Social Work</u>	<u>1,254,000</u>	<u>1,246,000</u>
652.15	<u>Base Level Adjustment.</u> The base is		
652.16	<u>\$1,248,000 in fiscal year 2020 and \$1,250,000</u>		
652.17	<u>in fiscal year 2021.</u>		
652.18	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>314,000</u>	<u>320,000</u>
652.19	<u>Base Level Adjustment.</u> The base is \$327,000		
652.20	<u>in fiscal year 2020 and \$333,000 in fiscal year</u>		
652.21	<u>2021.</u>		
652.22	<u>Subd. 16. Board of Behavioral Health and</u>		
652.23	<u>Therapy</u>	<u>771,000</u>	<u>643,000</u>
652.24	<u>Subd. 17. Board of Occupational Therapy</u>		
652.25	<u>Practice</u>	<u>374,000</u>	<u>328,000</u>
652.26	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
652.27	<u>REGULATORY BOARD</u> \$	<u>3,667,000</u> \$	<u>3,596,000</u>
652.28	<u>(a) Cooper/Sams Volunteer Ambulance</u>		
652.29	<u>Program.</u> \$950,000 in fiscal year 2018 and		
652.30	<u>\$950,000 in fiscal year 2019 are for the</u>		
652.31	<u>Cooper/Sams volunteer ambulance program</u>		
652.32	<u>under Minnesota Statutes, section 144E.40.</u>		

653.1 (1) Of this amount, \$861,000 in fiscal year
 653.2 2018 and \$861,000 in fiscal year 2019 are for
 653.3 the ambulance service personnel longevity
 653.4 award and incentive program under Minnesota
 653.5 Statutes, section 144E.40.

653.6 (2) Of this amount, \$89,000 in fiscal year 2018
 653.7 and \$89,000 in fiscal year 2019 are for the
 653.8 operations of the ambulance service personnel
 653.9 longevity award and incentive program under
 653.10 Minnesota Statutes, section 144E.40.

653.11 **(b) EMSRB Operations.** \$1,771,000 in fiscal
 653.12 year 2018 and \$1,700,000 in fiscal year 2019
 653.13 are for board operations. The base for this
 653.14 program is \$1,702,000 in fiscal year 2020 and
 653.15 \$1,702,000 in fiscal year 2021.

653.16 **(c) Regional Grants.** \$585,000 in fiscal year
 653.17 2018 and \$585,000 in fiscal year 2019 are for
 653.18 regional emergency medical services
 653.19 programs, to be distributed equally to the eight
 653.20 emergency medical service regions under
 653.21 Minnesota Statutes, section 144E.52.

653.22 **(d) Ambulance Training Grant.** \$361,000
 653.23 in fiscal year 2018 and \$361,000 in fiscal year
 653.24 2019 are for training grants under Minnesota
 653.25 Statutes, section 144E.35.

653.26 **(e) Base Level Adjustment.** The base is
 653.27 \$3,598,000 in fiscal year 2020 and \$3,598,000
 653.28 in fiscal year 2021.

653.29 Sec. 6. **COUNCIL ON DISABILITY** \$ **893,000** \$ **892,000**

653.30 **Base Level Adjustment.** The base is \$856,000
 653.31 in fiscal year 2020 and \$858,000 in fiscal year
 653.32 2021.

654.1 **Sec. 7. OMBUDSMAN FOR MENTAL**
 654.2 **HEALTH AND DEVELOPMENTAL**
 654.3 **DISABILITIES** **\$ 2,407,000 \$ 2,427,000**

654.4 **Department of Psychiatry Monitoring.**
 654.5 **\$100,000 in fiscal year 2018 and \$100,000 in**
 654.6 **fiscal year 2019 are for monitoring the**
 654.7 **Department of Psychiatry at the University of**
 654.8 **Minnesota.**

654.9 **Sec. 8. OMBUDSPERSONS FOR FAMILIES** **\$ 460,000 \$ 465,000**

654.10 Sec. 9. Laws 2009, chapter 101, article 1, section 12, is amended to read:

654.11 **Sec. 12. ADMINISTRATION**

654.12 **Subdivision 1. Total Appropriation** **\$ 19,973,000 \$ 19,617,000**

654.13	Appropriations by Fund	
654.14	2010	2011
654.15	General	19,723,000 19,617,000
654.16	Special Revenue	
654.17	Fund	250,000 0

654.18 The amounts that may be spent for each
 654.19 purpose are specified in the following
 654.20 subdivisions.

654.21 **Subd. 2. Government and Citizen Services** **18,097,000 17,766,000**

654.22	Appropriations by Fund	
654.23	General	17,847,000 17,766,000
654.24	Special Revenue	
654.25	Fund	250,000 0

654.26 (a) \$802,000 the first year and \$802,000 the
 654.27 second year are for the Minnesota Geospatial
 654.28 Information Office. Of the total appropriation,
 654.29 \$10,000 per year is intended for preparation
 654.30 of township acreage data in Laws 2008,
 654.31 chapter 366, article 17, section 7, subdivision
 654.32 3.

655.1 (b) \$74,000 the first year and \$74,000 the
655.2 second year are for the Council on
655.3 Developmental Disabilities.

655.4 ~~(c) \$127,000 the first year and \$127,000 the~~
655.5 ~~second year are for transfer to the~~
655.6 ~~commissioner of human services for a grant~~
655.7 ~~to the Council on Developmental Disabilities~~
655.8 ~~for the purpose of establishing a statewide~~
655.9 ~~self-advocacy network for persons with~~
655.10 ~~intellectual and developmental disabilities~~
655.11 ~~(ID/DD). The self-advocacy network shall:~~
655.12 ~~(1) ensure that persons with ID/DD are~~
655.13 ~~informed of their rights in employment,~~
655.14 ~~housing, transportation, voting, government~~
655.15 ~~policy, and other issues pertinent to the ID/DD~~
655.16 ~~community; (2) provide public education and~~
655.17 ~~awareness of the civil and human rights issues~~
655.18 ~~persons with ID/DD face; (3) provide funds,~~
655.19 ~~technical assistance, and other resources for~~
655.20 ~~self-advocacy groups across the state; and (4)~~
655.21 ~~organize systems of communications to~~
655.22 ~~facilitate an exchange of information between~~
655.23 ~~self-advocacy groups. This appropriation must~~
655.24 ~~be included in the base budget for the~~
655.25 ~~commissioner of human services for the~~
655.26 ~~biennium beginning July 1, 2011.~~

655.27 (d) \$250,000 the first year and \$170,000 the
655.28 second year are to fund activities to prepare
655.29 for and promote the 2010 census.

655.30 (e) \$206,000 the first year and \$206,000 the
655.31 second year are for the Office of the State
655.32 Archaeologist.

655.33 (f) \$8,388,000 the first year and \$8,388,000
655.34 the second year are for office space costs of
655.35 the legislature and veterans organizations, for

656.1 ceremonial space, and for statutorily free
656.2 space.

656.3 (g) \$3,500,000 of the balance in the facilities
656.4 repair and replacement account in the special
656.5 revenue fund is canceled to the general fund
656.6 on July 1, 2009. This is a onetime cancellation.

656.7 (h) The requirements imposed on the
656.8 commissioner of finance and the commissioner
656.9 of administration under Laws 2007, chapter
656.10 148, article 1, section 12, subdivision 2,
656.11 paragraph (b), relating to the savings
656.12 attributable to the real property portfolio
656.13 management system are inoperative.

656.14 (i) \$250,000 is appropriated to the
656.15 commissioner of administration from the
656.16 information and telecommunications account
656.17 in the special revenue fund to continue
656.18 planning for data center consolidation,
656.19 including beginning a predesign study and
656.20 lifecycle cost analysis, and exploring
656.21 technologies to reduce energy consumption
656.22 and operating costs.

656.23 **Subd. 3. Administrative Management Support** 1,876,000 1,851,000

656.24 \$125,000 each year is for the Office of Grant
656.25 Management. During the biennium ending
656.26 June 30, 2011, the commissioner must recover
656.27 this amount through deductions in state grants
656.28 subject to the jurisdiction of the office. The
656.29 commissioner may not deduct more than 2.5
656.30 percent from the amount of any grant. The
656.31 amount deducted from appropriations for these
656.32 grants must be deposited in the general fund.

656.33 \$25,000 the first year is for the Office of
656.34 Grants Management to study and make

657.1 recommendations on improving collaborative
 657.2 activities between the state, nonprofit entities,
 657.3 and the private sector, including: (1)
 657.4 recommendations for expanding successful
 657.5 initiatives involving not-for-profit
 657.6 organizations that have demonstrated
 657.7 measurable, positive results in addressing
 657.8 high-priority community issues; and (2)
 657.9 recommendations on grant requirements and
 657.10 design to encourage programs receiving grants
 657.11 to become self-sufficient. The office may
 657.12 appoint an advisory group to assist in the study
 657.13 and recommendations. The office must report
 657.14 its recommendations to the legislature by
 657.15 January 15, 2010.

657.16 Sec. 10. Laws 2012, chapter 247, article 6, section 2, subdivision 2, is amended to read:

657.17 Subd. 2. **Central Office Operations**

657.18 (a) Operations	118,000	356,000
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657.19 **Base Level Adjustment.** The general fund
 657.20 base is increased by \$91,000 in fiscal year
 657.21 2014 and \$44,000 in fiscal year 2015.

657.22 (b) Health Care	24,000	346,000
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657.23 This is a onetime appropriation.

657.24 **Managed Care Audit Activities.** In fiscal
 657.25 year 2014, ~~and in each even-numbered year~~
 657.26 ~~thereafter~~, the commissioner shall transfer
 657.27 from the health care access fund \$1,740,000
 657.28 to the legislative auditor for managed care
 657.29 audit services under Minnesota Statutes,
 657.30 section 256B.69, subdivision 9d. This is a
 657.31 biennial appropriation. The health care access
 657.32 fund base is increased by \$1,842,000 in fiscal
 657.33 year 2014. ~~Notwithstanding any contrary~~

658.1 ~~provision in this article, this paragraph does~~
 658.2 ~~not expire.~~

658.3 (c) Continuing Care	19,000	375,000
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658.4 **Base Level Adjustment.** The general fund
 658.5 base is decreased by \$159,000 in fiscal years
 658.6 2014 and 2015.

658.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

658.8 Sec. 11. Laws 2013, chapter 108, article 15, section 2, subdivision 2, is amended to read:

658.9 Subd. 2. **Central Office**

658.10 The amounts that may be spent from this
 658.11 appropriation for each purpose are as follows:

658.12 (a) Operations	2,909,000	8,957,000
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658.13 **Base Adjustment.** The general fund base is
 658.14 decreased by \$8,916,000 in fiscal year 2016
 658.15 and \$8,916,000 in fiscal year 2017.

658.16 (b) Children and Families	109,000	206,000
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658.17 (c) Continuing Care	2,849,000	3,574,000
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658.18 **Base Adjustment.** The general fund base is
 658.19 decreased by \$2,000 in fiscal year 2016 and
 658.20 by \$27,000 in fiscal year 2017.

658.21 (d) Group Residential Housing	(1,166,000)	(8,602,000)
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658.22 (e) Medical Assistance	(3,950,000)	(6,420,000)
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658.23 (f) Alternative Care	(7,386,000)	(6,851,000)
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658.24 (g) Child and Community Service Grants	3,000,000	3,000,000
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658.25 (h) Aging and Adult Services Grants	5,365,000	5,936,000
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658.26 ~~**Gaps Analysis.** In fiscal year 2014, and in~~
 658.27 ~~each even-numbered year thereafter, \$435,000~~
 658.28 ~~is appropriated to conduct an analysis of gaps~~
 658.29 ~~in long-term care services under Minnesota~~
 658.30 ~~Statutes, section 144A.351. This is a biennial~~
 658.31 ~~appropriation. The base is increased by~~
 658.32 ~~\$435,000 in fiscal year 2016. Notwithstanding~~

659.1 ~~any contrary provisions in this article, this~~
659.2 ~~provision does not expire.~~

659.3 **Base Adjustment.** The general fund base is
659.4 increased by \$498,000 in fiscal year 2016, and
659.5 decreased by \$124,000 in fiscal year 2017.

659.6 **(i) Disabilities Grants** 414,000 414,000

659.7 Sec. 12. Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended by Laws
659.8 2015, First Special Session chapter 6, section 2, is amended to read:

659.9 **Subd. 2. Health Improvement**

659.10 Appropriations by Fund			
659.11	General	68,653,000	68,984,000
659.12	State Government		
659.13	Special Revenue	6,264,000	6,182,000
659.14	Health Care Access	33,987,000	33,421,000
659.15	Federal TANF	11,713,000	11,713,000

659.16 **Violence Against Asian Women Working**
659.17 **Group.** \$200,000 in fiscal year 2016 from the
659.18 general fund is for the working group on
659.19 violence against Asian women and children.

659.20 **MERC Program.** \$1,000,000 in fiscal year
659.21 2016 and \$1,000,000 in fiscal year 2017 are
659.22 from the general fund for the MERC program
659.23 under Minnesota Statutes, section 62J.692,
659.24 subdivision 4.

659.25 **Poison Information Center Grants.**
659.26 \$750,000 in fiscal year 2016 and \$750,000 in
659.27 fiscal year 2017 are from the general fund for
659.28 regional poison information center grants
659.29 under Minnesota Statutes, section 145.93.

659.30 **Advanced Care Planning.** \$250,000 in fiscal
659.31 year 2016 is from the general fund to award
659.32 a grant to a statewide advance care planning
659.33 resource organization that has expertise in
659.34 convening and coordinating community-based

660.1 strategies to encourage individuals, families,
660.2 caregivers, and health care providers to begin
660.3 conversations regarding end-of-life care
660.4 choices that express an individual's health care
660.5 values and preferences and are based on
660.6 informed health care decisions. This is a
660.7 onetime appropriation.

660.8 **Early Dental Prevention Initiatives.**
660.9 \$172,000 in fiscal year 2016 and \$140,000 in
660.10 fiscal year 2017 are for the development and
660.11 distribution of the early dental prevention
660.12 initiative under Minnesota Statutes, section
660.13 144.3875.

660.14 **International Medical Graduate Assistance**
660.15 **Program.** (a) \$500,000 in fiscal year 2016
660.16 and \$500,000 in fiscal year 2017 are from the
660.17 health care access fund for the grant programs
660.18 and necessary contracts under Minnesota
660.19 Statutes, section 144.1911, subdivisions 3,
660.20 paragraph (a), clause (4), and 4 and 5. The
660.21 commissioner may use up to \$133,000 per
660.22 year of the appropriation for international
660.23 medical graduate assistance program
660.24 administration duties in Minnesota Statutes,
660.25 section 144.1911, subdivisions 3, 9, and 10,
660.26 and for administering the grant programs
660.27 under Minnesota Statutes, section 144.1911,
660.28 subdivisions 4, 5, and 6. The commissioner
660.29 shall develop recommendations for any
660.30 additional funding required for initiatives
660.31 needed to achieve the objectives of Minnesota
660.32 Statutes, section 144.1911. The commissioner
660.33 shall report the funding recommendations to
660.34 the legislature by January 15, 2016, in the
660.35 report required under Minnesota Statutes,

661.1 section 144.1911, subdivision 10. The base
661.2 for this purpose is \$1,000,000 in fiscal years
661.3 2018 and 2019.

661.4 (b) \$500,000 in fiscal year 2016 and \$500,000
661.5 in fiscal year 2017 are from the health care
661.6 access fund for transfer to the revolving
661.7 international medical graduate residency
661.8 account established in Minnesota Statutes,
661.9 section 144.1911, subdivision 6. This is a
661.10 onetime appropriation.

661.11 **Federally Qualified Health Centers.**

661.12 \$1,000,000 in fiscal year 2016 and \$1,000,000
661.13 in fiscal year 2017 are from the general fund
661.14 to provide subsidies to federally qualified
661.15 health centers under Minnesota Statutes,
661.16 section 145.9269. This is a onetime
661.17 appropriation.

661.18 **Organ Donation.** \$200,000 in fiscal year 2016
661.19 is from the general fund to establish a grant
661.20 program to develop and create culturally
661.21 appropriate outreach programs that provide
661.22 education about the importance of organ
661.23 donation. Grants shall be awarded to a
661.24 federally designated organ procurement
661.25 organization and hospital system that performs
661.26 transplants. This is a onetime appropriation.

661.27 **Primary Care Residency.** \$1,500,000 in
661.28 fiscal year 2016 and \$1,500,000 in fiscal year
661.29 2017 are from the general fund for the
661.30 purposes of the primary care residency
661.31 expansion grant program under Minnesota
661.32 Statutes, section 144.1506.

661.33 **~~Somali Women's Health Pilot~~ Autism**

661.34 **Program.** (a) The commissioner of health

662.1 shall ~~establish a pilot program between one or~~
662.2 ~~more federally qualified health centers, as~~
662.3 ~~defined under Minnesota Statutes, section~~
662.4 ~~145.9269, a nonprofit organization that helps~~
662.5 ~~Somali women, and the Minnesota Evaluation~~
662.6 ~~Studies Institute, to develop a promising~~
662.7 ~~strategy to address the preventative and~~
662.8 ~~primary health care needs of, and address~~
662.9 ~~health inequities experienced by, first~~
662.10 ~~generation Somali women. The pilot program~~
662.11 ~~must collaboratively develop a patient flow~~
662.12 ~~process for first generation Somali women by:~~
662.13 ~~(1) addressing and identifying clinical and~~
662.14 ~~cultural barriers to Somali women accessing~~
662.15 ~~preventative and primary care, including, but~~
662.16 ~~not limited to, cervical and breast cancer~~
662.17 ~~screenings;~~
662.18 ~~(2) developing a culturally appropriate health~~
662.19 ~~curriculum for Somali women based on the~~
662.20 ~~outcomes from the community-based~~
662.21 ~~participatory research report "Cultural~~
662.22 ~~Traditions and the Reproductive Health of~~
662.23 ~~Somali Refugees and Immigrants" to increase~~
662.24 ~~the health literacy of Somali women and~~
662.25 ~~develop culturally specific health care~~
662.26 ~~information; and~~
662.27 ~~(3) training the federally qualified health~~
662.28 ~~center's providers and staff to enhance~~
662.29 ~~provider and staff cultural competence~~
662.30 ~~regarding the cultural barriers, including~~
662.31 ~~female genital cutting.~~
662.32 ~~(b) The pilot program must develop a process~~
662.33 ~~that results in increased screening rates for~~
662.34 ~~cervical and breast cancer and can be~~
662.35 ~~replicated by other providers serving ethnic~~

663.1 ~~minorities. The pilot program must conduct~~
 663.2 ~~an evaluation of the new patient flow process~~
 663.3 ~~used by Somali women to access federally~~
 663.4 ~~qualified health centers services~~ award a grant
 663.5 to Dakota County to partner with a
 663.6 community-based organization with expertise
 663.7 in serving Somali children with autism. The
 663.8 grant must address barriers to accessing health
 663.9 care and other resources by providing outreach
 663.10 to Somali families on available support and
 663.11 training to providers on Somali culture.

663.12 (c) ~~The pilot program must report the~~
 663.13 ~~outcomes to the commissioner by June 30,~~
 663.14 ~~2017. The grantee shall report to the~~
 663.15 commissioner and the chairs and ranking
 663.16 minority members of the legislative
 663.17 committees with jurisdiction over health care
 663.18 policy and finance on the grant funds used and
 663.19 any notable outcomes achieved by January 15,
 663.20 2019.

663.21 (d) \$110,000 in fiscal year 2016 is for the
 663.22 ~~Somali women's health pilot program grant to~~
 663.23 Dakota County. Of this appropriation, the
 663.24 commissioner may use up to \$10,000 to
 663.25 administer the ~~program grant to Dakota~~
 663.26 County. This appropriation is available until
 663.27 June 30, 2017. This is a onetime appropriation.

663.28 **Menthol Cigarette Usage in**
 663.29 **African-American Community Intervention**
 663.30 **Grants.** Of the health care access fund
 663.31 appropriation for the statewide health
 663.32 improvement program, \$200,000 in fiscal year
 663.33 2016 is for at least one grant that must be
 663.34 awarded by the commissioner to implement
 663.35 strategies and interventions to reduce the

664.1 disproportionately high usage of cigarettes by
664.2 African-Americans, especially the use of
664.3 menthol-flavored cigarettes, as well as the
664.4 disproportionate harm tobacco causes in that
664.5 community. The grantee shall engage
664.6 members of the African-American community
664.7 and community-based organizations. This
664.8 grant shall be awarded as part of the statewide
664.9 health improvement program grants awarded
664.10 on November 1, 2015, and must meet the
664.11 requirements of Minnesota Statutes, section
664.12 145.986.

664.13 **Targeted Home Visiting System.** (a) \$75,000
664.14 in fiscal year 2016 is for the commissioner of
664.15 health, in consultation with the commissioners
664.16 of human services and education, community
664.17 health boards, tribal nations, and other home
664.18 visiting stakeholders, to design baseline
664.19 training for new home visitors to ensure
664.20 statewide coordination across home visiting
664.21 programs.

664.22 (b) \$575,000 in fiscal year 2016 and
664.23 \$2,000,000 fiscal year 2017 are to provide
664.24 grants to community health boards and tribal
664.25 nations for start-up grants for new
664.26 nurse-family partnership programs and for
664.27 grants to expand existing programs to serve
664.28 first-time mothers, prenatally by 28 weeks
664.29 gestation until the child is two years of age,
664.30 who are eligible for medical assistance under
664.31 Minnesota Statutes, chapter 256B, or the
664.32 federal Special Supplemental Nutrition
664.33 Program for Women, Infants, and Children.
664.34 The commissioner shall award grants to
664.35 community health boards or tribal nations in

665.1 metropolitan and rural areas of the state.
665.2 Priority for all grants shall be given to
665.3 nurse-family partnership programs that
665.4 provide services through a Minnesota health
665.5 care program-enrolled provider that accepts
665.6 medical assistance. Additionally, priority for
665.7 grants to rural areas shall be given to
665.8 community health boards and tribal nations
665.9 that expand services within regional
665.10 partnerships that provide the nurse-family
665.11 partnership program. Funding available under
665.12 this paragraph may only be used to
665.13 supplement, not to replace, funds being used
665.14 for nurse-family partnership home visiting
665.15 services as of June 30, 2015.

665.16 **Opiate Antagonists.** \$270,000 in fiscal year
665.17 2016 and \$20,000 in fiscal year 2017 are from
665.18 the general fund for grants to the eight regional
665.19 emergency medical services programs to
665.20 purchase opiate antagonists and educate and
665.21 train emergency medical services persons, as
665.22 defined in Minnesota Statutes, section
665.23 144.7401, subdivision 4, clauses (1) and (2),
665.24 in the use of these antagonists in the event of
665.25 an opioid or heroin overdose. For the purposes
665.26 of this paragraph, "opiate antagonist" means
665.27 naloxone hydrochloride or any similarly acting
665.28 drug approved by the federal Food and Drug
665.29 Administration for the treatment of drug
665.30 overdose. Grants under this paragraph must
665.31 be distributed to all eight regional emergency
665.32 medical services programs. This is a onetime
665.33 appropriation and is available until June 30,
665.34 2017. The commissioner may use up to
665.35 \$20,000 of the amount for opiate antagonists
665.36 for administration.

666.1 **Local and Tribal Public Health Grants. (a)**
666.2 \$894,000 in fiscal year 2016 and \$894,000 in
666.3 fiscal year 2017 are for an increase in local
666.4 public health grants for community health
666.5 boards under Minnesota Statutes, section
666.6 145A.131, subdivision 1, paragraph (e).

666.7 (b) \$106,000 in fiscal year 2016 and \$106,000
666.8 in fiscal year 2017 are for an increase in
666.9 special grants to tribal governments under
666.10 Minnesota Statutes, section 145A.14,
666.11 subdivision 2a.

666.12 **HCBS Employee Scholarships. \$1,000,000**
666.13 in fiscal year 2016 and \$1,000,000 in fiscal
666.14 year 2017 are from the general fund for the
666.15 home and community-based services
666.16 employee scholarship program under
666.17 Minnesota Statutes, section 144.1503. The
666.18 commissioner may use up to \$50,000 of the
666.19 amount for the HCBS employee scholarships
666.20 for administration.

666.21 **Family Planning Special Projects.**
666.22 \$1,000,000 in fiscal year 2016 and \$1,000,000
666.23 in fiscal year 2017 are from the general fund
666.24 for family planning special project grants
666.25 under Minnesota Statutes, section 145.925.

666.26 **Positive Alternatives. \$1,000,000 in fiscal**
666.27 year 2016 and \$1,000,000 in fiscal year 2017
666.28 are from the general fund for positive abortion
666.29 alternatives under Minnesota Statutes, section
666.30 145.4235.

666.31 **Safe Harbor for Sexually Exploited Youth.**
666.32 \$700,000 in fiscal year 2016 and \$700,000 in
666.33 fiscal year 2017 are from the general fund for
666.34 the safe harbor program under Minnesota

667.1 Statutes, sections 145.4716 to 145.4718. Funds
667.2 shall be used for grants to increase the number
667.3 of regional navigators; training for
667.4 professionals who engage with exploited or
667.5 at-risk youth; implementing statewide
667.6 protocols and best practices for effectively
667.7 identifying, interacting with, and referring
667.8 sexually exploited youth to appropriate
667.9 resources; and program operating costs.

667.10 **Health Care Grants for Uninsured**

667.11 **Individuals.** (a) \$62,500 in fiscal year 2016
667.12 and \$62,500 in fiscal year 2017 are from the
667.13 health care access fund for dental provider
667.14 grants in Minnesota Statutes, section 145.929,
667.15 subdivision 1.

667.16 (b) \$218,750 in fiscal year 2016 and \$218,750
667.17 in fiscal year 2017 are from the health care
667.18 access fund for community mental health
667.19 program grants in Minnesota Statutes, section
667.20 145.929, subdivision 2.

667.21 (c) \$750,000 in fiscal year 2016 and \$750,000
667.22 in fiscal year 2017 are from the health care
667.23 access fund for the emergency medical
667.24 assistance outlier grant program in Minnesota
667.25 Statutes, section 145.929, subdivision 3.

667.26 (d) \$218,750 of the health care access fund
667.27 appropriation in fiscal year 2016 and \$218,750
667.28 in fiscal year 2017 are for community health
667.29 center grants under Minnesota Statutes, section
667.30 145.9269. A community health center that
667.31 receives a grant from this appropriation is not
667.32 eligible for a grant under paragraph (b).

667.33 (e) The commissioner may use up to \$25,000
667.34 of the appropriations for health care grants for

668.1 uninsured individuals in fiscal years 2016 and
668.2 2017 for grant administration.

668.3 **TANF Appropriations.** (a) \$1,156,000 of the
668.4 TANF funds is appropriated each year of the
668.5 biennium to the commissioner for family
668.6 planning grants under Minnesota Statutes,
668.7 section 145.925.

668.8 (b) \$3,579,000 of the TANF funds is
668.9 appropriated each year of the biennium to the
668.10 commissioner for home visiting and nutritional
668.11 services listed under Minnesota Statutes,
668.12 section 145.882, subdivision 7, clauses (6) and
668.13 (7). Funds must be distributed to community
668.14 health boards according to Minnesota Statutes,
668.15 section 145A.131, subdivision 1.

668.16 (c) \$2,000,000 of the TANF funds is
668.17 appropriated each year of the biennium to the
668.18 commissioner for decreasing racial and ethnic
668.19 disparities in infant mortality rates under
668.20 Minnesota Statutes, section 145.928,
668.21 subdivision 7.

668.22 (d) \$4,978,000 of the TANF funds is
668.23 appropriated each year of the biennium to the
668.24 commissioner for the family home visiting
668.25 grant program according to Minnesota
668.26 Statutes, section 145A.17. \$4,000,000 of the
668.27 funding must be distributed to community
668.28 health boards according to Minnesota Statutes,
668.29 section 145A.131, subdivision 1. \$978,000 of
668.30 the funding must be distributed to tribal
668.31 governments as provided in Minnesota
668.32 Statutes, section 145A.14, subdivision 2a.

668.33 (e) The commissioner may use up to 6.23
668.34 percent of the funds appropriated each fiscal

669.1 year to conduct the ongoing evaluations
669.2 required under Minnesota Statutes, section
669.3 145A.17, subdivision 7, and training and
669.4 technical assistance as required under
669.5 Minnesota Statutes, section 145A.17,
669.6 subdivisions 4 and 5.

669.7 **TANF Carryforward.** Any unexpended
669.8 balance of the TANF appropriation in the first
669.9 year of the biennium does not cancel but is
669.10 available for the second year.

669.11 **Health Professional Loan Forgiveness.**
669.12 \$2,631,000 in fiscal year 2016 and \$2,631,000
669.13 in fiscal year 2017 are from the health care
669.14 access fund for the purposes of Minnesota
669.15 Statutes, section 144.1501. Of this
669.16 appropriation, the commissioner may use up
669.17 to \$131,000 each year to administer the
669.18 program.

669.19 **Minnesota Stroke System.** \$350,000 in fiscal
669.20 year 2016 and \$350,000 in fiscal year 2017
669.21 are from the general fund for the Minnesota
669.22 stroke system.

669.23 **Prevention of Violence in Health Care.**
669.24 \$50,000 in fiscal year 2016 is to continue the
669.25 prevention of violence in health care program
669.26 and creating violence prevention resources for
669.27 hospitals and other health care providers to
669.28 use in training their staff on violence
669.29 prevention. This is a onetime appropriation
669.30 and is available until June 30, 2017.

669.31 **Health Care Savings Determinations.** (a)
669.32 The health care access fund base for the state
669.33 health improvement program is decreased by

670.1 \$261,000 in fiscal year 2016 and decreased
670.2 by \$110,000 in fiscal year 2017.

670.3 (b) \$261,000 in fiscal year 2016 and \$110,000
670.4 in fiscal year 2017 are from the health care
670.5 access fund for the forecasting, cost reporting,
670.6 and analysis required by Minnesota Statutes,
670.7 section 62U.10, subdivisions 6 and 7.

670.8 **Base Level Adjustments.** The general fund
670.9 base is decreased by \$1,070,000 in fiscal year
670.10 2018 and by \$1,020,000 in fiscal year 2019.
670.11 The state government special revenue fund
670.12 base is increased by \$33,000 in fiscal year
670.13 2018. The health care access fund base is
670.14 increased by \$610,000 in fiscal year 2018 and
670.15 by \$23,000 in fiscal year 2019.

670.16 Sec. 13. Laws 2017, chapter 2, article 1, section 2, subdivision 3, is amended to read:

670.17 Subd. 3. **Payments to health carriers.** (a) The commissioner shall make payments to
670.18 health carriers on behalf of eligible individuals effectuating coverage for calendar year 2017,
670.19 for the months in that year for which the individual has paid the net premium amount to the
670.20 health carrier. Payments to health carriers shall be based on the premium subsidy available
670.21 to eligible individuals in the individual market, regardless of the cost of coverage purchased.
670.22 The commissioner shall not withhold payments because a health carrier cannot prove an
670.23 enrollee is an eligible individual.

670.24 (b) Health carriers seeking reimbursement from the commissioner must submit an invoice
670.25 and supporting information to the commissioner, using a form developed by the
670.26 commissioner, in order to be eligible for payment. The commissioner shall finalize the form
670.27 by March 1, 2017.

670.28 (c) Total state payments to health carriers must be made within the limits of the available
670.29 appropriation. The commissioner shall reimburse health carriers at the full requested amount
670.30 up to the level of the appropriation. The commissioner, by July 15, 2017, shall determine
670.31 whether the available appropriation will be sufficient to provide premium subsidies equal
670.32 to 25 percent of the gross premium for the period September 1, 2017, through December
670.33 31, 2017. If the commissioner determines that the available appropriation is not sufficient,
670.34 the commissioner shall reduce the premium subsidy percentage, beginning September 1,

671.1 2017, through the remainder of the calendar year, by an amount sufficient to ensure that the
671.2 total amount of premium subsidies provided for the calendar year does not exceed the
671.3 available appropriation. The commissioner shall notify health carriers of any reduced
671.4 premium subsidy percentage within five days of making a determination. Health carriers
671.5 shall provide enrollees with at least 30 days' notice of any reduction in the premium subsidy
671.6 percentage.

671.7 (d) The commissioner shall consider health carriers as vendors under Minnesota Statutes,
671.8 section 16A.124, subdivision 3, and each monthly invoice shall represent the completed
671.9 delivery of the service.

671.10 (e) The commissioner, with the November 2017 forecast, shall certify the extent to which
671.11 appropriations exceed forecast obligations under this subdivision. Notwithstanding Laws
671.12 2017, chapter 2, article 1, section 7, the estimated value of available funds, up to \$98,779,000,
671.13 shall be canceled to the general fund. The cancellation in this paragraph shall be reduced
671.14 by any difference in medical assistance expenditures estimated in the trend calculation under
671.15 section 15.

671.16 Sec. 14. **IMPLEMENTATION OF CONTINGENT APPROPRIATIONS.**

671.17 Notwithstanding Laws 2017, chapter 2, article 1, section 7, and upon certification of
671.18 excess funds in accordance with Laws 2017, chapter 2, article 1, section 2, subdivision 3,
671.19 up to \$1,388,000 in fiscal year 2018 and up to \$15,102,000 in fiscal year 2019 are
671.20 appropriated to the commissioner of human services for central office operations in fiscal
671.21 year 2019. This appropriation is onetime.

671.22 Sec. 15. **TREND LIMIT; CALCULATION.**

671.23 Beginning January 1, 2019, and ending June 30, 2021, the commissioner may limit the
671.24 trend increase in rates paid to managed care plans and county-based purchasing plans under
671.25 Minnesota Statutes, sections 256B.69 and 256B.692, by an amount equal to the value of a
671.26 0.5 percent reduction in trend in medical assistance. Managed care rates must meet actuarial
671.27 soundness and rate development requirements under Code of Federal Regulations, title 42,
671.28 part 438, subpart A.

671.29 In the November 2017 forecast, the commissioner of human services, in consultation
671.30 with the commissioner of management and budget, shall determine the extent to which the
671.31 limits in managed care trend growth are forecasted to reduce medical assistance expenditures
671.32 in fiscal years 2019 through 2021. Any reduction estimated shall reduce the cancellation in
671.33 Laws 2017, chapter 2, article 1, section 2, subdivision 3, paragraph (e), by up to \$82,289,000.

672.1 Sec. 16. **TRANSFERS.**

672.2 Subdivision 1. Grants. The commissioner of human services, with the approval of the
672.3 commissioner of management and budget, may transfer unencumbered appropriation balances
672.4 for the biennium ending June 30, 2019, within fiscal years among the MFIP, general
672.5 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
672.6 Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing
672.7 programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
672.8 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
672.9 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
672.10 and ranking minority members of the senate Health and Human Services Finance and Policy
672.11 Committee, the senate Human Services Reform Finance and Policy Committee, and the
672.12 house of representatives Health and Human Services Finance Committee quarterly about
672.13 transfers made under this subdivision.

672.14 Subd. 2. Administration. Positions, salary money, and nonsalary administrative money
672.15 may be transferred within the Departments of Health and Human Services as the
672.16 commissioners consider necessary, with the advance approval of the commissioner of
672.17 management and budget. The commissioner shall inform the chairs and ranking minority
672.18 members of the senate Health and Human Services Finance and Policy Committee, the
672.19 senate Human Services Reform Finance and Policy Committee, and the house of
672.20 representatives Health and Human Services Finance Committee quarterly about transfers
672.21 made under this subdivision.

672.22 Sec. 17. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

672.23 The commissioners of health and human services shall not use indirect cost allocations
672.24 to pay for the operational costs of any program for which they are responsible.

672.25 Sec. 18. **EXPIRATION OF UNCODIFIED LANGUAGE.**

672.26 All uncodified language contained in this article expires on June 30, 2019, unless a
672.27 different expiration date is explicit.

672.28 Sec. 19. **EFFECTIVE DATE.**

672.29 This article is effective July 1, 2017, unless a different effective date is specified.

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Article locations in 17-4723

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ARTICLE 2	HOUSING	Page.Ln 57.26
ARTICLE 3	CONTINUING CARE	Page.Ln 103.1
ARTICLE 4	HEALTH CARE	Page.Ln 150.14
ARTICLE 5	HEALTH INSURANCE	Page.Ln 220.18
ARTICLE 6	DIRECT CARE AND TREATMENT	Page.Ln 226.1
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ARTICLE 11	HEALTH LICENSING BOARDS	Page.Ln 455.4
ARTICLE 12	OPIATE ABUSE PREVENTION	Page.Ln 499.24
ARTICLE 13	MISCELLANEOUS	Page.Ln 502.26
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ARTICLE 16	CHILD CARE DEVELOPMENT BLOCK GRANT COMPLIANCE ..	Page.Ln 544.6
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ARTICLE 18	APPROPRIATIONS	Page.Ln 609.14

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

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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,

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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;

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(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.

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(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.

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(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

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(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

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(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

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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,

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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.

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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

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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.

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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 14.57 to 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.

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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 9530.6505 do 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

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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

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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.

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(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.

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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;

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- 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;

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(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.

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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 9530.6400 is 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.

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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;

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- (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

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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.

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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.

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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.

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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.