

SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 800

(SENATE AUTHORS: BENSON and Abeler)

DATE	D-PG	OFFICIAL STATUS
02/09/2017	554	Introduction and first reading Referred to Health and Human Services Finance and Policy
03/27/2017	1966	Author added Abeler
03/28/2017	2190a	Comm report: To pass as amended and re-refer to Finance
03/29/2017		Comm report: To pass as amended Second reading

1.1 A bill for an act

1.2 relating to human services finance and policy; appropriating money for human

1.3 services and health-related programs; modifying various provisions governing

1.4 community supports, housing, continuing care, health care, managed care

1.5 organizations, health insurance, direct care and treatment, children and families,

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

1.7 Department of Health policy, and health licensing boards; establishing a license

1.8 for substance abuse disorder treatment; authorizing transfers; providing for

1.9 supplemental rates; modifying reimbursement rates and premium scales; making

1.10 forecast adjustments; providing for audits; authorizing pilot projects; requiring

1.11 reports; establishing a legislative commission; making technical and terminology

1.12 changes; amending Minnesota Statutes 2016, sections 3.972, by adding a

1.13 subdivision; 13.32, by adding a subdivision; 13.46, subdivisions 1, 2, 4; 13.69,

1.14 subdivision 1; 13.84, subdivision 5; 62A.04, subdivision 1; 62A.21, subdivision

1.15 2a; 62A.3075; 62A.65, subdivisions 2, 5, by adding a subdivision; 62D.105,

1.16 subdivisions 1, 2; 62E.04, subdivision 11; 62E.05, subdivision 1; 62E.06, by adding

1.17 a subdivision; 62Q.18, subdivision 7; 62U.02; 62V.05, subdivision 12; 103I.101,

1.18 subdivisions 2, 5; 103I.111, subdivisions 6, 7, 8; 103I.205; 103I.301; 103I.501;

1.19 103I.505; 103I.515; 103I.535, subdivisions 3, 6, by adding a subdivision; 103I.541;

1.20 103I.545, subdivisions 1, 2; 103I.711, subdivision 1; 103I.715, subdivision 2;

1.21 119B.011, by adding subdivisions; 119B.02, subdivision 5; 119B.09, subdivision

1.22 9a; 119B.125, subdivisions 4, 6; 119B.13, subdivisions 1, 6; 119B.16, subdivisions

1.23 1, 1a, 1b, by adding subdivisions; 144.05, subdivision 6; 144.0724, subdivisions

1.24 4, 6; 144.122; 144.1501, subdivision 2; 144.551, subdivision 1; 144A.071,

1.25 subdivision 4d; 144A.351; 144A.472, subdivision 7; 144A.474, subdivision 11;

1.26 144A.4799, subdivision 3; 144A.70, subdivision 6, by adding a subdivision;

1.27 144D.04, subdivision 2, by adding a subdivision; 144D.06; 145.4716, subdivision

1.28 2; 145.986, subdivision 1a; 146B.02, subdivisions 2, 5, 8, by adding subdivisions;

1.29 146B.03, subdivisions 6, 7; 146B.07, subdivision 4; 146B.10, subdivision 1; 147.01,

1.30 subdivision 7; 147.02, subdivision 1; 147.03, subdivision 1; 147B.08, by adding

1.31 a subdivision; 147C.40, by adding a subdivision; 148.5194, subdivision 7; 148.6402,

1.32 subdivision 4; 148.6405; 148.6408, subdivision 2; 148.6410, subdivision 2;

1.33 148.6412, subdivision 2; 148.6415; 148.6418, subdivisions 1, 2, 4, 5; 148.6420,

1.34 subdivisions 1, 3, 5; 148.6423; 148.6425, subdivisions 2, 3; 148.6428; 148.6443,

1.35 subdivisions 5, 6, 7, 8; 148.6445, subdivisions 1, 10; 148.6448; 157.16, subdivision

1.36 1; 214.01, subdivision 2; 245.4889, subdivision 1; 245.91, subdivisions 4, 6;

1.37 245.94, subdivision 1; 245.97, subdivision 6; 245A.02, subdivision 2b, by adding

1.38 a subdivision; 245A.03, subdivisions 2, 7; 245A.04, subdivision 14; 245A.06,

1.39 subdivision 2; 245A.07, subdivision 3; 245A.11, by adding subdivisions; 245A.191;

2.1 245A.50, subdivision 5; 245D.03, subdivision 1; 245D.04, subdivision 3; 245D.071,
 2.2 subdivision 3; 245D.11, subdivision 4; 245D.24, subdivision 3; 245E.01, by adding
 2.3 a subdivision; 245E.02, subdivisions 1, 3, 4; 245E.03, subdivisions 2, 4; 245E.04;
 2.4 245E.05, subdivision 1; 245E.06, subdivisions 1, 2, 3; 245E.07, subdivision 1;
 2.5 252.27, subdivision 2a; 252.41, subdivision 3; 253B.10, subdivision 1; 253B.22,
 2.6 subdivision 1; 254A.01; 254A.02, subdivisions 2, 3, 5, 6, 8, 10, by adding
 2.7 subdivisions; 254A.03; 254A.035, subdivision 1; 254A.04; 254A.08; 254A.09;
 2.8 254A.19, subdivision 3; 254B.01, subdivision 3, by adding a subdivision; 254B.03,
 2.9 subdivision 2; 254B.04, subdivisions 1, 2b; 254B.05, subdivisions 1, 1a, 5;
 2.10 254B.051; 254B.07; 254B.08; 254B.09; 254B.12, subdivision 2; 254B.13,
 2.11 subdivision 2a; 256.01, subdivision 41, by adding a subdivision; 256.045,
 2.12 subdivision 3; 256.969, subdivisions 2b, 4b, by adding a subdivision; 256.975,
 2.13 subdivision 7, by adding a subdivision; 256.98, subdivision 8; 256B.04,
 2.14 subdivisions 21, 22; 256B.055, subdivision 2; 256B.0621, subdivision 10;
 2.15 256B.0625, subdivisions 7, 20, 45a, 57, 64, by adding subdivisions; 256B.0659,
 2.16 subdivisions 1, 2, 11, 21, by adding a subdivision; 256B.072; 256B.0755,
 2.17 subdivisions 1, 3, 4, by adding a subdivision; 256B.0911, subdivisions 1a, 3a, 4d,
 2.18 by adding subdivisions; 256B.0915, subdivisions 1, 1a, 3a, 3e, 3h, 5, by adding
 2.19 subdivisions; 256B.092, subdivision 4; 256B.0922, subdivision 1; 256B.0924, by
 2.20 adding a subdivision; 256B.0943, subdivision 13; 256B.0945, subdivisions 2, 4;
 2.21 256B.196, subdivision 2; 256B.431, subdivisions 10, 16, 30; 256B.434, subdivisions
 2.22 4, 4f; 256B.49, subdivisions 11, 15; 256B.4913, subdivision 4a, by adding a
 2.23 subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 16; 256B.493,
 2.24 subdivisions 1, 2, by adding a subdivision; 256B.50, subdivision 1b; 256B.5012,
 2.25 by adding a subdivision; 256B.69, subdivision 9e; 256B.76, subdivisions 1, 2;
 2.26 256B.766; 256B.85, subdivisions 3, 5, 6; 256C.23, subdivision 2, by adding
 2.27 subdivisions; 256C.233, subdivisions 1, 2; 256C.24, subdivisions 1, 2, by adding
 2.28 a subdivision; 256C.261; 256D.44, subdivisions 4, 5; 256E.30, subdivision 2;
 2.29 256I.03, subdivision 8; 256I.04, subdivisions 1, 2d, 2g, 3; 256I.05, subdivisions
 2.30 1a, 1c, 1e, 1j, 1m, 8, by adding subdivisions; 256I.06, subdivisions 2, 8; 256J.24,
 2.31 subdivision 5; 256J.45, subdivision 2; 256L.03, subdivisions 1, 1a, 5; 256L.15,
 2.32 subdivision 2; 256P.06, subdivision 2; 256R.02, subdivisions 4, 18; 256R.07, by
 2.33 adding a subdivision; 256R.10, by adding a subdivision; 256R.37; 256R.40,
 2.34 subdivision 5; 256R.41; 256R.47; 256R.49, subdivision 1; 260C.451, subdivision
 2.35 6; 317A.811, subdivision 1, by adding a subdivision; 327.15, subdivision 3;
 2.36 609.5315, subdivision 5c; 626.556, subdivisions 2, 3, 3c, 10d, 10j; Laws 2009,
 2.37 chapter 101, article 1, section 12; Laws 2012, chapter 247, article 6, section 2,
 2.38 subdivision 2; Laws 2013, chapter 108, article 15, section 2, subdivision 2; Laws
 2.39 2014, chapter 312, article 23, section 9, subdivision 8, by adding a subdivision;
 2.40 Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended; Laws
 2.41 2017, chapter 2, article 1, sections 1, subdivision 3; 2, subdivision 4, by adding a
 2.42 subdivision; 3; 5; 7; article 2, section 13; proposing coding for new law in
 2.43 Minnesota Statutes, chapters 62Q; 119B; 144; 144D; 145; 147A; 148; 245; 245A;
 2.44 256; 256B; 256I; 256N; 256R; 317A; proposing coding for new law as Minnesota
 2.45 Statutes, chapters 144H; 245G; repealing Minnesota Statutes 2016, sections 13.468;
 2.46 147A.21; 147B.08, subdivisions 1, 2, 3; 147C.40, subdivisions 1, 2, 3, 4; 148.6402,
 2.47 subdivision 2; 148.6450; 245A.1915; 245A.192; 254A.02, subdivision 4;
 2.48 256B.0659, subdivision 22; 256B.19, subdivision 1c; 256B.4914, subdivision 16;
 2.49 256B.64; 256C.23, subdivision 3; 256C.233, subdivision 4; 256C.25, subdivisions
 2.50 1, 2; 256J.626, subdivision 5; Laws 2014, chapter 312, article 23, section 9,
 2.51 subdivision 5; Minnesota Rules, parts 5600.2500; 9530.6405, subparts 1, 1a, 2, 3,
 2.52 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20,
 2.53 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430;
 2.54 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465;
 2.55 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500;
 2.56 9530.6505.

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

3.1 **ARTICLE 1**

3.2 **COMMUNITY SUPPORTS**

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

3.4 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
 3.5 **REPORT AND STUDY REQUIRED.**

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

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

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

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

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

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

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

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

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

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

4.2 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home
4.3 and community-based services to persons with disabilities and persons age 65 and older
4.4 pursuant to this chapter. The licensing standards in this chapter govern the provision of
4.5 basic support services and intensive support services.

4.6 (b) Basic support services provide the level of assistance, supervision, and care that is
4.7 necessary to ensure the health and welfare of the person and do not include services that
4.8 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
4.9 person. Basic support services include:

4.10 (1) in-home and out-of-home respite care services as defined in section 245A.02,
4.11 subdivision 15, and under the brain injury, community alternative care, community access
4.12 for disability inclusion, developmental disability, and elderly waiver plans, excluding
4.13 out-of-home respite care provided to children in a family child foster care home licensed
4.14 under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license
4.15 holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,
4.16 or successor provisions; and section 245D.061 or successor provisions, which must be
4.17 stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000,
4.18 subpart 4;

4.19 (2) adult companion services as defined under the brain injury, community access for
4.20 disability inclusion, and elderly waiver plans, excluding adult companion services provided
4.21 under the Corporation for National and Community Services Senior Companion Program
4.22 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

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

4.24 (4) 24-hour emergency assistance, personal emergency response as defined under the
4.25 community access for disability inclusion and developmental disability waiver plans;

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

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

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

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

5.4 (1) intervention services, including:

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

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

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

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

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

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

5.16 (iii) semi-independent living services; and

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

5.19 (3) residential supports and services, including:

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

5.23 (ii) foster care services as defined in the brain injury, community alternative care, and
5.24 community access for disability inclusion waiver plans provided in a family or corporate
5.25 child foster care residence, a family adult foster care residence, or a community residential
5.26 setting; and

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

5.29 (4) day services, including:

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

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

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

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

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

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

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

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

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

6.20 Subd. 3. **Day training and habilitation services for adults with developmental**
6.21 **disabilities.** (a) "Day training and habilitation services for adults with developmental
6.22 disabilities" means services that:

6.23 (1) include supervision, training, assistance, ~~and supported employment,~~ center-based
6.24 work-related activities, or other community-integrated activities designed and implemented
6.25 in accordance with the individual service and individual habilitation plans required under
6.26 Minnesota Rules, parts 9525.0004 to 9525.0036, to help an adult reach and maintain the
6.27 highest possible level of independence, productivity, and integration into the community;
6.28 and

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

6.31 (b) Day training and habilitation services reimbursable under this section do not include
6.32 special education and related services as defined in the Education of the Individuals with

7.1 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17),
7.2 or vocational services funded under section 110 of the Rehabilitation Act of 1973, United
7.3 States Code, title 29, section 720, as amended.

7.4 (c) Day training and habilitation services do not include employment exploration,
7.5 employment development, or employment support services as defined in the home and
7.6 community-based services waivers for people with disabilities authorized under sections
7.7 256B.092 and 256B.49.

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

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

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

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

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

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

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

7.23 (b) An organization receiving a grant under paragraph (a) must be an organization
7.24 governed by people with intellectual and developmental disabilities that administers a
7.25 statewide network of disability groups in order to maintain and promote self-advocacy
7.26 services and supports for persons with intellectual and developmental disabilities throughout
7.27 the state.

7.28 (c) An organization receiving a grant under paragraph (a) must use the funds for the
7.29 following purposes:

7.30 (1) to maintain the infrastructure needed to train and support the activities of a statewide
7.31 network of peer-to-peer mentors for people with developmental disabilities, focused on
7.32 building awareness of service options and advocacy skills necessary to move toward full

8.1 inclusion in community life, including the development and delivery of the curriculum to
 8.2 support the peer-to-peer network;

8.3 (2) to provide outreach activities, including statewide conferences and disability
 8.4 networking opportunities focused on self-advocacy, informed choice, and community
 8.5 engagement skills;

8.6 (3) to provide an annual leadership program for persons with intellectual and
 8.7 developmental disabilities; and

8.8 (4) to provide for administrative and general operating costs associated with managing
 8.9 and maintaining facilities, program delivery, evaluation, staff, and technology.

8.10 Sec. 5. Minnesota Statutes 2016, section 256B.0659, subdivision 1, is amended to read:

8.11 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
 8.12 paragraphs (b) to ~~(r)~~ (s) have the meanings given unless otherwise provided in text.

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

8.15 (c) "Behavior," effective January 1, 2010, means a category to determine the home care
 8.16 rating and is based on the criteria found in this section. "Level I behavior" means physical
 8.17 aggression towards self, others, or destruction of property that requires the immediate
 8.18 response of another person.

8.19 (d) "Complex health-related needs," effective January 1, 2010, means a category to
 8.20 determine the home care rating and is based on the criteria found in this section.

8.21 (e) "Complex personal care assistance services" means personal care assistance services:

8.22 (1) for a person who qualifies for ten hours or more of personal care assistance services
 8.23 per day; and

8.24 (2) provided by a personal care assistant who is qualified to provide complex personal
 8.25 assistance services under subdivision 11, paragraph (d).

8.26 ~~(e)~~ (f) "Critical activities of daily living," effective January 1, 2010, means transferring,
 8.27 mobility, eating, and toileting.

8.28 ~~(f)~~ (g) "Dependency in activities of daily living" means a person requires assistance to
 8.29 begin and complete one or more of the activities of daily living.

8.30 ~~(g)~~ (h) "Extended personal care assistance service" means personal care assistance
 8.31 services included in a service plan under one of the home and community-based services

9.1 waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which
 9.2 exceed the amount, duration, and frequency of the state plan personal care assistance services
 9.3 for participants who:

9.4 (1) need assistance provided periodically during a week, but less than daily will not be
 9.5 able to remain in their homes without the assistance, and other replacement services are
 9.6 more expensive or are not available when personal care assistance services are to be reduced;
 9.7 or

9.8 (2) need additional personal care assistance services beyond the amount authorized by
 9.9 the state plan personal care assistance assessment in order to ensure that their safety, health,
 9.10 and welfare are provided for in their homes.

9.11 ~~(h)~~ (i) "Health-related procedures and tasks" means procedures and tasks that can be
 9.12 delegated or assigned by a licensed health care professional under state law to be performed
 9.13 by a personal care assistant.

9.14 ~~(i)~~ (j) "Instrumental activities of daily living" means activities to include meal planning
 9.15 and preparation; basic assistance with paying bills; shopping for food, clothing, and other
 9.16 essential items; performing household tasks integral to the personal care assistance services;
 9.17 communication by telephone and other media; and traveling, including to medical
 9.18 appointments and to participate in the community.

9.19 ~~(j)~~ (k) "Managing employee" has the same definition as Code of Federal Regulations,
 9.20 title 42, section 455.

9.21 ~~(k)~~ (l) "Qualified professional" means a professional providing supervision of personal
 9.22 care assistance services and staff as defined in section 256B.0625, subdivision 19c.

9.23 ~~(l)~~ (m) "Personal care assistance provider agency" means a medical assistance enrolled
 9.24 provider that provides or assists with providing personal care assistance services and includes
 9.25 a personal care assistance provider organization, personal care assistance choice agency,
 9.26 class A licensed nursing agency, and Medicare-certified home health agency.

9.27 ~~(m)~~ (n) "Personal care assistant" or "PCA" means an individual employed by a personal
 9.28 care assistance agency who provides personal care assistance services.

9.29 ~~(n)~~ (o) "Personal care assistance care plan" means a written description of personal care
 9.30 assistance services developed by the personal care assistance provider according to the
 9.31 service plan.

9.32 ~~(o)~~ (p) "Responsible party" means an individual who is capable of providing the support
 9.33 necessary to assist the recipient to live in the community.

10.1 ~~(p)~~ (q) "Self-administered medication" means medication taken orally, by injection,
 10.2 nebulizer, or insertion, or applied topically without the need for assistance.

10.3 ~~(q)~~ (r) "Service plan" means a written summary of the assessment and description of the
 10.4 services needed by the recipient.

10.5 ~~(r)~~ (s) "Wages and benefits" means wages and salaries, the employer's share of FICA
 10.6 taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage
 10.7 reimbursement, health and dental insurance, life insurance, disability insurance, long-term
 10.8 care insurance, uniform allowance, and contributions to employee retirement accounts.

10.9 **EFFECTIVE DATE.** This section is effective July 1, 2018.

10.10 Sec. 6. Minnesota Statutes 2016, section 256B.0659, subdivision 2, is amended to read:

10.11 Subd. 2. **Personal care assistance services; covered services.** (a) The personal care
 10.12 assistance services eligible for payment include services and supports furnished to an
 10.13 individual, as needed, to assist in:

10.14 (1) activities of daily living;

10.15 (2) health-related procedures and tasks;

10.16 (3) observation and redirection of behaviors; and

10.17 (4) instrumental activities of daily living.

10.18 (b) Activities of daily living include the following covered services:

10.19 (1) dressing, including assistance with choosing, application, and changing of clothing
 10.20 and application of special appliances, wraps, or clothing;

10.21 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
 10.22 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
 10.23 except for recipients who are diabetic or have poor circulation;

10.24 (3) bathing, including assistance with basic personal hygiene and skin care;

10.25 (4) eating, including assistance with hand washing and application of orthotics required
 10.26 for eating, transfers, and feeding;

10.27 (5) transfers, including assistance with transferring the recipient from one seating or
 10.28 reclining area to another;

10.29 (6) mobility, including assistance with ambulation, including use of a wheelchair.

10.30 Mobility does not include providing transportation for a recipient;

11.1 (7) positioning, including assistance with positioning or turning a recipient for necessary
11.2 care and comfort; and

11.3 (8) toileting, including assistance with helping recipient with bowel or bladder elimination
11.4 and care including transfers, mobility, positioning, feminine hygiene, use of toileting
11.5 equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting
11.6 clothing.

11.7 (c) Health-related procedures and tasks include the following covered services:

11.8 (1) range of motion and passive exercise to maintain a recipient's strength and muscle
11.9 functioning;

11.10 (2) assistance with self-administered medication as defined by this section, including
11.11 reminders to take medication, bringing medication to the recipient, and assistance with
11.12 opening medication under the direction of the recipient or responsible party, including
11.13 medications given through a nebulizer;

11.14 (3) interventions for seizure disorders, including monitoring and observation; and

11.15 (4) other activities considered within the scope of the personal care service and meeting
11.16 the definition of health-related procedures and tasks under this section.

11.17 (d) A personal care assistant may provide health-related procedures and tasks associated
11.18 with the complex health-related needs of a recipient if the procedures and tasks meet the
11.19 definition of health-related procedures and tasks under this section and the personal care
11.20 assistant is trained by a qualified professional and demonstrates competency to safely
11.21 complete the procedures and tasks. Delegation of health-related procedures and tasks and
11.22 all training must be documented in the personal care assistance care plan and the recipient's
11.23 and personal care assistant's files. A personal care assistant must not determine the medication
11.24 dose or time for medication.

11.25 (e) Effective January 1, 2010, for a personal care assistant to provide the health-related
11.26 procedures and tasks of tracheostomy suctioning and services to recipients on ventilator
11.27 support there must be:

11.28 (1) delegation and training by a registered nurse, certified or licensed respiratory therapist,
11.29 or a physician;

11.30 (2) utilization of clean rather than sterile procedure;

11.31 (3) specialized training about the health-related procedures and tasks and equipment,
11.32 including ventilator operation and maintenance;

12.1 (4) individualized training regarding the needs of the recipient; and

12.2 (5) supervision by a qualified professional who is a registered nurse.

12.3 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
 12.4 recipient for episodes where there is a need for redirection due to behaviors. Training of
 12.5 the personal care assistant must occur based on the needs of the recipient, the personal care
 12.6 assistance care plan, and any other support services provided.

12.7 (g) Instrumental activities of daily living under subdivision 1, paragraph ~~(h)~~ (j).

12.8 **EFFECTIVE DATE.** This section is effective July 1, 2018.

12.9 Sec. 7. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

12.10 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
 12.11 meet the following requirements:

12.12 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
 12.13 age with these additional requirements:

12.14 (i) supervision by a qualified professional every 60 days; and

12.15 (ii) employment by only one personal care assistance provider agency responsible for
 12.16 compliance with current labor laws;

12.17 (2) be employed by a personal care assistance provider agency;

12.18 (3) enroll with the department as a personal care assistant after clearing a background
 12.19 study. Except as provided in subdivision 11a, before a personal care assistant provides
 12.20 services, the personal care assistance provider agency must initiate a background study on
 12.21 the personal care assistant under chapter 245C, and the personal care assistance provider
 12.22 agency must have received a notice from the commissioner that the personal care assistant
 12.23 is:

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

12.25 (ii) is disqualified, but the personal care assistant has received a set aside of the
 12.26 disqualification under section 245C.22;

12.27 (4) be able to effectively communicate with the recipient and personal care assistance
 12.28 provider agency;

12.29 (5) be able to provide covered personal care assistance services according to the recipient's
 12.30 personal care assistance care plan, respond appropriately to recipient needs, and report
 12.31 changes in the recipient's condition to the supervising qualified professional or physician;

13.1 (6) not be a consumer of personal care assistance services;

13.2 (7) maintain daily written records including, but not limited to, time sheets under
13.3 subdivision 12;

13.4 (8) effective January 1, 2010, complete standardized training as determined by the
13.5 commissioner before completing enrollment. The training must be available in languages
13.6 other than English and to those who need accommodations due to disabilities. Personal care
13.7 assistant training must include successful completion of the following training components:
13.8 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
13.9 roles and responsibilities of personal care assistants including information about assistance
13.10 with lifting and transfers for recipients, emergency preparedness, orientation to positive
13.11 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
13.12 training components, the personal care assistant must demonstrate the competency to provide
13.13 assistance to recipients;

13.14 (9) complete training and orientation on the needs of the recipient; and

13.15 (10) be limited to providing and being paid for up to 275 hours per month of personal
13.16 care assistance services regardless of the number of recipients being served or the number
13.17 of personal care assistance provider agencies enrolled with. The number of hours worked
13.18 per day shall not be disallowed by the department unless in violation of the law.

13.19 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
13.20 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

13.21 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,
13.22 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care
13.23 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of
13.24 a residential setting.

13.25 (d) A personal care assistant is qualified to provide complex personal care assistance
13.26 services defined in subdivision 1, paragraph (e), if the personal care assistant:

13.27 (1) provides services according to the care plan in subdivision 7 to an individual described
13.28 in subdivision 1, paragraph (e), clause (1); and

13.29 (2) beginning July 1, 2018, satisfies the current requirements of Medicare for training
13.30 and competency or competency evaluation of home health aides or nursing assistants, as
13.31 provided by Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative,
13.32 comparable, state-approved training and competency requirements.

13.33 **EFFECTIVE DATE.** This section is effective July 1, 2018.

14.1 Sec. 8. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision
14.2 to read:

14.3 Subd. 17a. **Rate for complex personal care assistance services.** The rate paid to a
14.4 provider for complex personal care assistance services shall be 110 percent of the rate paid
14.5 for personal care assistance services.

14.6 **EFFECTIVE DATE.** This section is effective July 1, 2018.

14.7 Sec. 9. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

14.8 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
14.9 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
14.10 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
14.11 a format determined by the commissioner, information and documentation that includes,
14.12 but is not limited to, the following:

14.13 (1) the personal care assistance provider agency's current contact information including
14.14 address, telephone number, and e-mail address;

14.15 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
14.16 revenue in the previous calendar year is up to and including \$300,000, the provider agency
14.17 must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is
14.18 over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety
14.19 bond must be in a form approved by the commissioner, must be renewed annually, and must
14.20 allow for recovery of costs and fees in pursuing a claim on the bond;

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

14.22 (4) proof of workers' compensation insurance coverage;

14.23 (5) proof of liability insurance;

14.24 (6) a description of the personal care assistance provider agency's organization identifying
14.25 the names of all owners, managing employees, staff, board of directors, and the affiliations
14.26 of the directors, owners, or staff to other service providers;

14.27 (7) a copy of the personal care assistance provider agency's written policies and
14.28 procedures including: hiring of employees; training requirements; service delivery; and
14.29 employee and consumer safety including process for notification and resolution of consumer
14.30 grievances, identification and prevention of communicable diseases, and employee
14.31 misconduct;

- 15.1 (8) copies of all other forms the personal care assistance provider agency uses in the
15.2 course of daily business including, but not limited to:
- 15.3 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
15.4 varies from the standard time sheet for personal care assistance services approved by the
15.5 commissioner, and a letter requesting approval of the personal care assistance provider
15.6 agency's nonstandard time sheet;
- 15.7 (ii) the personal care assistance provider agency's template for the personal care assistance
15.8 care plan; and
- 15.9 (iii) the personal care assistance provider agency's template for the written agreement
15.10 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;
- 15.11 (9) a list of all training and classes that the personal care assistance provider agency
15.12 requires of its staff providing personal care assistance services;
- 15.13 (10) documentation that the personal care assistance provider agency and staff have
15.14 successfully completed all the training required by this section, including the requirements
15.15 under subdivision 11, paragraph (d), if complex personal care assistance services are provided
15.16 and submitted for payment;
- 15.17 (11) documentation of the agency's marketing practices;
- 15.18 (12) disclosure of ownership, leasing, or management of all residential properties that
15.19 is used or could be used for providing home care services;
- 15.20 (13) documentation that the agency will use the following percentages of revenue
15.21 generated from the medical assistance rate paid for personal care assistance services for
15.22 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
15.23 care assistance choice option and 72.5 percent of revenue from other personal care assistance
15.24 providers. The revenue generated by the qualified professional and the reasonable costs
15.25 associated with the qualified professional shall not be used in making this calculation; and
- 15.26 (14) effective May 15, 2010, documentation that the agency does not burden recipients'
15.27 free exercise of their right to choose service providers by requiring personal care assistants
15.28 to sign an agreement not to work with any particular personal care assistance recipient or
15.29 for another personal care assistance provider agency after leaving the agency and that the
15.30 agency is not taking action on any such agreements or requirements regardless of the date
15.31 signed.
- 15.32 (b) Personal care assistance provider agencies shall provide the information specified
15.33 in paragraph (a) to the commissioner at the time the personal care assistance provider agency

16.1 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
16.2 the information specified in paragraph (a) from all personal care assistance providers
16.3 beginning July 1, 2009.

16.4 (c) All personal care assistance provider agencies shall require all employees in
16.5 management and supervisory positions and owners of the agency who are active in the
16.6 day-to-day management and operations of the agency to complete mandatory training as
16.7 determined by the commissioner before enrollment of the agency as a provider. Employees
16.8 in management and supervisory positions and owners who are active in the day-to-day
16.9 operations of an agency who have completed the required training as an employee with a
16.10 personal care assistance provider agency do not need to repeat the required training if they
16.11 are hired by another agency, if they have completed the training within the past three years.
16.12 By September 1, 2010, the required training must be available with meaningful access
16.13 according to title VI of the Civil Rights Act and federal regulations adopted under that law
16.14 or any guidance from the United States Health and Human Services Department. The
16.15 required training must be available online or by electronic remote connection. The required
16.16 training must provide for competency testing. Personal care assistance provider agency
16.17 billing staff shall complete training about personal care assistance program financial
16.18 management. This training is effective July 1, 2009. Any personal care assistance provider
16.19 agency enrolled before that date shall, if it has not already, complete the provider training
16.20 within 18 months of July 1, 2009. Any new owners or employees in management and
16.21 supervisory positions involved in the day-to-day operations are required to complete
16.22 mandatory training as a requisite of working for the agency. Personal care assistance provider
16.23 agencies certified for participation in Medicare as home health agencies are exempt from
16.24 the training required in this subdivision. When available, Medicare-certified home health
16.25 agency owners, supervisors, or managers must successfully complete the competency test.

16.26 Sec. 10. Minnesota Statutes 2016, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

- 17.1 (3) development of an individual's person-centered community support plan;
- 17.2 (4) providing information regarding eligibility for Minnesota health care programs;
- 17.3 (5) face-to-face long-term care consultation assessments, which may be completed in a
17.4 hospital, nursing facility, intermediate care facility for persons with developmental disabilities
17.5 (ICF/DDs), regional treatment centers, or the person's current or planned residence;
- 17.6 (6) determination of home and community-based waiver and other service eligibility as
17.7 required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
17.8 determination for individuals who need an institutional level of care as determined under
17.9 subdivision 4e, based on assessment and community support plan development, appropriate
17.10 referrals to obtain necessary diagnostic information, and including an eligibility determination
17.11 for consumer-directed community supports;
- 17.12 (7) providing recommendations for institutional placement when there are no
17.13 cost-effective community services available;
- 17.14 (8) providing access to assistance to transition people back to community settings after
17.15 institutional admission; and
- 17.16 (9) providing information about competitive employment, with or without supports, for
17.17 school-age youth and working-age adults and referrals to the Disability Linkage Line and
17.18 Disability Benefits 101 to ensure that an informed choice about competitive employment
17.19 can be made. For the purposes of this subdivision, "competitive employment" means work
17.20 in the competitive labor market that is performed on a full-time or part-time basis in an
17.21 integrated setting, and for which an individual is compensated at or above the minimum
17.22 wage, but not less than the customary wage and level of benefits paid by the employer for
17.23 the same or similar work performed by individuals without disabilities.
- 17.24 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
17.25 and 3a, "long-term care consultation services" also means:
- 17.26 (1) service eligibility determination for state plan home care services identified in:
- 17.27 (i) section 256B.0625, subdivisions 7, 19a, and 19c;
- 17.28 (ii) consumer support grants under section 256.476; or
- 17.29 (iii) section 256B.85;
- 17.30 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
17.31 determination of eligibility for case management services available under sections 256B.0621,
17.32 subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

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

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

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

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

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

18.17 (f) "Person-centered planning" includes the active participation of a person with a
 18.18 disability in the person's services and program, including in making meaningful and informed
 18.19 choices about the person's own goals and objectives, as well as making meaningful and
 18.20 informed choices about the services the person receives. For the purposes of this paragraph,
 18.21 "informed choice" means the process of the person with a disability choosing from all
 18.22 available service options based on accurate and complete information concerning all available
 18.23 service options and concerning the person's own preferences, abilities, goals, and objectives.
 18.24 In order for a person to make an informed choice, all available options must be developed
 18.25 and presented to the person by a partnership consisting of the person and the individuals
 18.26 that will empower the consumer to make decisions.

18.27 Sec. 11. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

18.28 Subd. 3a. **Initial assessment and support planning.** (a) Persons requesting initial
 18.29 assessment, initial services planning, or other assistance intended to support community-based
 18.30 living, including persons who need assessment in order to determine initial waiver or
 18.31 alternative care program eligibility, must be visited by a long-term care consultation team
 18.32 within 20 calendar days after the date on which an initial assessment was requested or
 18.33 recommended. ~~Upon statewide implementation of subdivisions 2b, 2c, and 5, This~~

19.1 requirement also applies to an initial assessment of a person requesting personal care
19.2 assistance services and home care nursing. ~~The commissioner shall provide at least a 90-day~~
19.3 ~~notice to lead agencies prior to the effective date of this requirement.~~ Face-to-face initial
19.4 assessments must be conducted according to paragraphs (b) to (i).

19.5 (b) ~~Upon implementation of subdivisions 2b, 2c, and 5,~~ Lead agencies shall use certified
19.6 assessors to conduct the initial assessment. For a person with complex health care needs, a
19.7 public health or registered nurse from the team must be consulted.

19.8 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
19.9 be used to complete a an initial comprehensive, person-centered assessment. The initial
19.10 assessment must include the health, psychological, functional, environmental, and social
19.11 needs of the individual necessary to develop a community support plan that meets the
19.12 individual's needs and preferences.

19.13 (d) The initial assessment must be conducted in a face-to-face interview with the person
19.14 being assessed and the person's legal representative. At the request of the person, other
19.15 individuals may participate in the assessment to provide information on the needs, strengths,
19.16 and preferences of the person necessary to develop a community support plan that ensures
19.17 the person's health and safety. Except for legal representatives or family members invited
19.18 by the person, persons participating in the assessment may not be a provider of service or
19.19 have any financial interest in the provision of services. For persons who are to be initially
19.20 assessed for elderly waiver customized living services under section 256B.0915, with the
19.21 permission of the person being assessed or the person's designated or legal representative,
19.22 the client's current or proposed provider of services may submit a copy of the provider's
19.23 nursing assessment or written report outlining its recommendations regarding the client's
19.24 care needs. The person conducting the assessment must notify the provider of the date by
19.25 which this information is to be submitted. This information shall be provided to the person
19.26 conducting the assessment prior to the assessment. For a person who is to be initially assessed
19.27 for waiver services under section 256B.092 or 256B.49, with the permission of the person
19.28 being assessed or the person's designated legal representative, the person's current provider
19.29 of services may submit a written report outlining recommendations regarding the person's
19.30 care needs prepared by a direct service employee with at least 20 hours of service to that
19.31 client. The person conducting the assessment ~~or reassessment~~ must notify the provider of
19.32 the date by which this information is to be submitted. This information shall be provided
19.33 to the person conducting the assessment and the person or the person's legal representative,
19.34 and must be considered prior to the finalization of the assessment or reassessment.

20.1 (e) The person or the person's legal representative must be provided with a written
20.2 community support plan within 40 calendar days of the initial assessment visit, regardless
20.3 of whether the individual is eligible for Minnesota health care programs. The written
20.4 community support plan must include:

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

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

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

20.10 (4) referral information; and

20.11 (5) informal caregiver supports, if applicable.

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

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

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

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

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

20.28 (2) documentation that the most cost-effective alternatives available, including
20.29 independent living, were offered to the individual. For purposes of this clause,
20.30 "cost-effective" means community services and living arrangements that cost the same as
20.31 or less than institutional care or corporate foster care. For an individual found to meet
20.32 eligibility criteria for home and community-based service programs under section 256B.0915

21.1 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver
 21.2 plan for each program;

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

21.9 (4) the role of long-term care consultation assessment and support planning in eligibility
 21.10 determination for waiver and alternative care programs, and state plan home care, case
 21.11 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
 21.12 and (b);

21.13 (5) information about Minnesota health care programs;

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

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

21.17 (8) the certified assessor's decision regarding the person's need for institutional level of
 21.18 care as determined under criteria established in subdivision 4e, the certified assessor's
 21.19 decision regarding the person's need for corporate foster care, and the certified assessor's
 21.20 decision regarding the person's eligibility for all services and programs as defined in
 21.21 subdivision 1a, paragraphs (a), clause (6), and (b); and

21.22 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
 21.23 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
 21.24 (8), and (b), ~~and incorporating~~ the certified assessor's decision regarding the need for
 21.25 institutional level of care, the certified assessor's decision regarding the need for corporate
 21.26 foster care, or the lead agency's final decisions regarding public programs eligibility according
 21.27 to section 256.045, subdivision 3.

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

22.1 (j) The effective eligibility start date for programs in paragraph (i) can never be prior to
22.2 the date of initial assessment. If an initial assessment was completed more than 60 days
22.3 before the effective waiver or alternative care program eligibility start date, assessment and
22.4 support plan information must be updated and documented in the department's Medicaid
22.5 Management Information System (MMIS). Notwithstanding retroactive medical assistance
22.6 coverage of state plan services, the effective date of eligibility for programs included in
22.7 paragraph (i) cannot be prior to the date the ~~most recent updated~~ initial assessment is
22.8 completed.

22.9 Sec. 12. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision
22.10 to read:

22.11 Subd. 3f. **Service updates and modifications.** (a) A service update may substitute for
22.12 an annual reassessment under this section and Minnesota Rules, part 9525.0016, whenever
22.13 permitted by federal law and either there is not a significant change in a person's condition
22.14 or there is not a change in the person's needs for services. Service updates must be completed
22.15 face-to-face annually unless completed by phone. A service update may be completed by
22.16 telephone only if the person is able to participate in the update by telephone and no more
22.17 than two consecutive service updates are completed by phone.

22.18 (b) A service update must include a review of the most recent written community support
22.19 plan and home care plan, as well as a review of the initial baseline data, evaluation of service
22.20 effectiveness, modification of service plan and appropriate referrals, update of initial
22.21 assessment or most recent reassessment forms, obtaining service authorizations, and ongoing
22.22 consumer education.

22.23 (c) To the extent permitted by federal law, a service modification may substitute for a
22.24 reassessment otherwise required under this chapter following a change in condition or a
22.25 change in eligibility.

22.26 (d) A service update or service modification must be documented in a manner determined
22.27 by the commissioner.

22.28 (e) If the person receiving services or the person's legal representative requests a
22.29 reassessment under subdivision 3g, a service update or service modification must not be
22.30 substituted for a reassessment.

23.1 Sec. 13. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision
23.2 to read:

23.3 Subd. 3g. **Annual reassessments and other reassessments.** (a) All reassessments must
23.4 be conducted according to subdivision 3a.

23.5 (b) Any person who received an initial assessment under subdivision 3a and whose
23.6 continued eligibility for medical assistance services under federal law requires an annual
23.7 reassessment must be reassessed annually.

23.8 (c) If an annual reassessment is not required under federal law for a person who received
23.9 an initial assessment under subdivision 3a, lead agencies are not required to perform an
23.10 annual reassessment unless the person or the person's legal representative requests an annual
23.11 reassessment or the person has experienced a significant change in condition.

23.12 Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 4d, is amended to read:

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

23.17 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing
23.18 facility must be screened prior to admission according to the requirements outlined in section
23.19 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as
23.20 required under section 256.975, subdivision 7.

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

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

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

23.30 (f) In the event that an individual under 65 years of age is admitted to a nursing facility
23.31 on an emergency basis, the Senior LinkAge Line must be notified of the admission on the

24.1 next working day, and a face-to-face initial assessment as described in paragraph (c) must
 24.2 be conducted within 40 calendar days of admission.

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

24.11 (h) An individual under 65 years of age residing in a nursing facility whose condition
 24.12 is likely to change shall receive a face-to-face ~~assessment~~ reassessment under subdivision
 24.13 3g at least every 12 months to review the person's service choices and available alternatives
 24.14 unless the individual indicates, in writing, that annual visits are not desired. In this case, the
 24.15 individual must receive a face-to-face ~~assessment~~ reassessment at least once every 36 months
 24.16 for the same purposes.

24.17 (i) An individual under 65 years of age residing in a nursing facility whose condition is
 24.18 unlikely to change may, upon request, receive a face-to-face reassessment under subdivision
 24.19 3g. An individual who does not request a reassessment under this paragraph must receive
 24.20 an annual service update under subdivision 3f.

24.21 (j) Notwithstanding the provisions of subdivision 6, the commissioner may pay county
 24.22 agencies directly for face-to-face initial assessments or reassessments for individuals under
 24.23 65 years of age who are being considered for placement or residing in a nursing facility.

24.24 ~~(j)~~ (k) Funding for preadmission screening follow-up shall be provided to the Disability
 24.25 Linkage Line for the under-60 population by the Department of Human Services to cover
 24.26 options counseling salaries and expenses to provide the services described in subdivisions
 24.27 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to
 24.28 employ, within the limits of available funding, sufficient personnel to provide preadmission
 24.29 screening follow-up services and shall seek to maximize federal funding for the service as
 24.30 provided under section 256.01, subdivision 2, paragraph (dd).

24.31 Sec. 15. Minnesota Statutes 2016, section 256B.0915, subdivision 1a, is amended to read:

24.32 Subd. 1a. **Elderly waiver case management services.** (a) Except as provided to
 24.33 individuals under prepaid medical assistance programs as described in paragraph (h), case

25.1 management services under the home and community-based services waiver for elderly
25.2 individuals are available from providers meeting qualification requirements and the standards
25.3 specified in subdivision 1b. Eligible recipients may choose any qualified provider of case
25.4 management services.

25.5 (b) Case management services assist individuals who receive waiver services in gaining
25.6 access to needed waiver and other state plan services and assist individuals in appeals under
25.7 section 256.045, as well as needed medical, social, educational, and other services regardless
25.8 of the funding source for the services to which access is gained. Case managers shall
25.9 collaborate with consumers, families, legal representatives, and relevant medical experts
25.10 and service providers in the development and periodic review of the coordinated service
25.11 and support plan.

25.12 (c) A case aide shall provide assistance to the case manager in carrying out administrative
25.13 activities of the case management function. The case aide may not assume responsibilities
25.14 that require professional judgment including assessments, reassessments, and care plan
25.15 development. The case manager is responsible for providing oversight of the case aide.

25.16 (d) Case managers shall be responsible for ongoing monitoring of the provision of
25.17 services included in the individual's plan of care. Case managers shall initiate the process
25.18 of reassessment of the individual's coordinated service and support plan and review the plan
25.19 at intervals specified in the federally approved waiver plan.

25.20 (e) The county of service or tribe must provide access to and arrange for case management
25.21 services. County of service has the meaning given it in Minnesota Rules, part 9505.0015,
25.22 subpart 11.

25.23 (f) Except as described in paragraph (h), case management services must be provided
25.24 by a public or private agency that is enrolled as a medical assistance provider determined
25.25 by the commissioner to meet all of the requirements in subdivision 1b. Case management
25.26 services must not be provided to a recipient by a private agency that has a financial interest
25.27 in the provision of any other services included in the recipient's coordinated service and
25.28 support plan. For purposes of this section, "private agency" means any agency that is not
25.29 identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

25.30 (g) Case management service activities provided to or arranged for a person include:

25.31 (1) development of the coordinated service and support plan under subdivision 6;

25.32 (2) informing the individual or the individual's legal guardian or conservator of service
25.33 options, and options for case management services and providers;

26.1 (3) consulting with relevant medical experts or service providers;

26.2 (4) assisting the person in the identification of potential providers;

26.3 (5) assisting the person to access services;

26.4 (6) coordination of services; and

26.5 (7) evaluation and monitoring of the services identified in the plan, which must

26.6 ~~incorporate at least one annual~~ include a face-to-face visit by the case manager with each

26.7 person at the request of the individual or the individual's legal guardian or conservator of

26.8 service options.

26.9 (h) Notwithstanding any requirements in this section, for individuals enrolled in prepaid

26.10 medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan

26.11 shall provide or arrange to provide elderly waiver case management services in paragraph

26.12 (g), in accordance with contract requirements established by the commissioner.

26.13 Sec. 16. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

26.14 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall

26.15 receive an initial assessment of strengths, informal supports, and need for services in

26.16 accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment ~~of a client~~

26.17 ~~served~~ under the elderly waiver must be conducted ~~at least every 12 months and at other~~

26.18 ~~times~~ according to section 256B.0911, subdivision 3g, when the case manager determines

26.19 that there has been significant change in the client's functioning or at the request of the client

26.20 or the client's legal guardian or conservator of service options. This may include instances

26.21 where the client is discharged from the hospital. There must be a determination that the

26.22 client requires nursing facility level of care as defined in section 256B.0911, subdivision

26.23 4e, at an initial assessment under section 256B.0911, subdivision 3a, and any subsequent

26.24 assessments reassessments under section 256B.0911, subdivision 3g, or annual service

26.25 updates under section 256B.0911, subdivision 3f, to initiate and maintain participation in

26.26 the waiver program.

26.27 (b) Regardless of other assessments identified in section 144.0724, subdivision 4, as

26.28 appropriate to determine nursing facility level of care for purposes of medical assistance

26.29 payment for nursing facility services, only face-to-face initial assessments conducted

26.30 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility

26.31 level of care determination will be accepted for purposes of initial ~~and ongoing~~ access to

26.32 waiver service payment. Only reassessments conducted according to section 256B.0911,

26.33 subdivision 3g, that result in a nursing facility level of need determination or annual service

27.1 updates conducted according to section 256B.0911, subdivision 3f, that demonstrate no
27.2 improvement in the client's condition shall be accepted for the purposes of ongoing access
27.3 to waiver service payments.

27.4 Sec. 17. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

27.5 Subd. 15. **Coordinated service and support plan; comprehensive transitional service**
27.6 **plan; maintenance service plan.** (a) Each recipient of home and community-based waived
27.7 services shall be provided a copy of the written coordinated service and support plan which
27.8 meets the requirements in section 256B.092, subdivision 1b.

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

27.18 Within ten days following an assessment, a comprehensive transitional service plan must
27.19 be developed incorporating elements of a comprehensive functional assessment and including
27.20 short-term measurable outcomes and timelines for achievement of and reporting on these
27.21 outcomes. Functional milestones must also be identified and reported according to the
27.22 timelines agreed upon by the transitional service planning team. In addition, the
27.23 comprehensive transitional service plan must identify additional supports that may assist
27.24 in the achievement of the fundamental service outcome such as the development of greater
27.25 natural community support, increased collaboration among agencies, and technological
27.26 supports.

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

27.33 For those whose fundamental transitional service outcome involves the need to procure
27.34 housing, a plan for the recipient to seek the resources necessary to secure the least restrictive

28.1 housing possible should be incorporated into the plan, including employment and public
28.2 supports such as housing access and shelter needy funding.

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

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

28.17 (e) When a county is evaluating denials, reductions, or terminations of home and
28.18 community-based services under this section for an individual, the case manager shall offer
28.19 to meet with the individual or the individual's guardian in order to discuss the prioritization
28.20 of service needs within the coordinated service and support plan, comprehensive transitional
28.21 service plan, or maintenance service plan. The reduction in the authorized services for an
28.22 individual due to changes in funding for waived services may not exceed the amount
28.23 needed to ensure medically necessary services to meet the individual's health, safety, and
28.24 welfare.

28.25 (f) At the time of reassessment, local agency case managers shall assess each recipient
28.26 of community access for disability inclusion or brain injury waived services currently
28.27 residing in a licensed adult foster home that is not the primary residence of the license
28.28 holder, or in which the license holder is not the primary caregiver, to determine if that
28.29 recipient could appropriately be served in a community-living setting. If appropriate for the
28.30 recipient, the case manager shall offer the recipient, through a person-centered planning
28.31 process, the option to receive alternative housing and service options. In the event that the
28.32 recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled
28.33 with another recipient of waiver services and group residential housing and the licensed
28.34 capacity shall be reduced accordingly, unless the savings required by the licensed bed closure
28.35 reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40,

29.1 paragraph (f), for foster care settings where the physical location is not the primary residence
29.2 of the license holder are met through voluntary changes described in section 245A.03,
29.3 subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the
29.4 adult foster home becomes no longer viable due to these transfers, the county agency, with
29.5 the assistance of the department, shall facilitate a consolidation of settings or closure. This
29.6 reassessment process shall be completed by July 1, 2013.

29.7 Sec. 18. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

29.8 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
29.9 "implementation period" means the period beginning January 1, 2014, and ending on the
29.10 last day of the month in which the rate management system is populated with the data
29.11 necessary to calculate rates for substantially all individuals receiving home and
29.12 community-based waiver services under sections 256B.092 and 256B.49. "Banding period"
29.13 means the time period beginning on January 1, 2014, and ending upon the expiration of the
29.14 12-month period defined in paragraph (c), clause (5).

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

29.18 (1) for a day service recipient who was not authorized to receive these waiver services
29.19 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
29.20 changed providers on or after January 1, 2014, the historical rate must be the weighted
29.21 average authorized rate for the provider number in the county of service, effective December
29.22 1, 2013; or

29.23 (2) for a unit-based service with programming or a unit-based service without
29.24 programming recipient who was not authorized to receive these waiver services prior to
29.25 January 1, 2014; added a new service or services on or after January 1, 2014; or changed
29.26 providers on or after January 1, 2014, the historical rate must be the weighted average
29.27 authorized rate for each provider number in the county of service, effective December 1,
29.28 2013; or

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

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

30.3 (1) 0.5 percent from the historical rate for the implementation period;

30.4 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately
30.5 following the time period of clause (1);

30.6 (3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately
30.7 following the time period of clause (2);

30.8 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately
30.9 following the time period of clause (3);

30.10 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately
30.11 following the time period of clause (4); ~~and~~

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

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

30.19 (d) The commissioner shall review all changes to rates that were in effect on December
30.20 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service
30.21 unit utilization on an annual basis as those in effect on October 31, 2013.

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

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

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

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

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

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

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

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

31.10 Sec. 19. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision
31.11 to read:

31.12 Subd. 7. **New services.** (a) A service added to section 256B.4914 after January 1, 2014,
31.13 is not subject to rate stabilization adjustment in this section.

31.14 (b) Employment support services authorized after January 1, 2018, under the new
31.15 employment support services definition according to the home and community-based services
31.16 waivers for people with disabilities under sections 256B.092 and 256B.49 are not subject
31.17 to rate stabilization adjustment in this section.

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

31.19 Sec. 20. Minnesota Statutes 2016, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

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

32.1 (f) "Individual staffing" means the time spent as a one-to-one interaction specific to an
32.2 individual recipient by staff to provide direct support and assistance with activities of daily
32.3 living, instrumental activities of daily living, and training to participants, and is based on
32.4 the requirements in each individual's coordinated service and support plan under section
32.5 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
32.6 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
32.7 needs must also be considered.

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

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

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

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

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

32.19 (l) "Shared staffing" means time spent by employees, not defined under paragraph (f),
32.20 providing or available to provide more than one individual with direct support and assistance
32.21 with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph
32.22 (b); instrumental activities of daily living as defined under section 256B.0659, subdivision
32.23 1, paragraph (i); ancillary activities needed to support individual services; and training to
32.24 participants, and is based on the requirements in each individual's coordinated service and
32.25 support plan under section 245D.02, subdivision 4b; any coordinated service and support
32.26 plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider
32.27 observation of an individual's service need. Total shared staffing hours are divided
32.28 proportionally by the number of individuals who receive the shared service provisions.

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

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

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

33.4 (2) for day services under subdivision 7:

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

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

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

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

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

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

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

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

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

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

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

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

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

33.28 Sec. 21. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

33.29 Subd. 3. **Applicable services.** Applicable services are those authorized under the state's
 33.30 home and community-based services waivers under sections 256B.092 and 256B.49,

- 34.1 including the following, as defined in the federally approved home and community-based
34.2 services plan:
- 34.3 (1) 24-hour customized living;
 - 34.4 (2) adult day care;
 - 34.5 (3) adult day care bath;
 - 34.6 (4) behavioral programming;
 - 34.7 (5) companion services;
 - 34.8 (6) customized living;
 - 34.9 (7) day training and habilitation;
 - 34.10 (8) housing access coordination;
 - 34.11 (9) independent living skills;
 - 34.12 (10) in-home family support;
 - 34.13 (11) night supervision;
 - 34.14 (12) personal support;
 - 34.15 (13) prevocational services;
 - 34.16 (14) residential care services;
 - 34.17 (15) residential support services;
 - 34.18 (16) respite services;
 - 34.19 (17) structured day services;
 - 34.20 ~~(18) supported employment services;~~
 - 34.21 ~~(19)~~ (18) supported living services;
 - 34.22 ~~(20)~~ (19) transportation services; ~~and~~
 - 34.23 (20) individualized home supports;
 - 34.24 (21) independent living skills specialist services;
 - 34.25 (22) employment exploration services;
 - 34.26 (23) employment development services;
 - 34.27 (24) employment support services; and

35.1 ~~(21)~~ (25) other services as approved by the federal government in the state home and
 35.2 community-based services plan.

35.3 **EFFECTIVE DATE.** (a) Clause (20) is effective the day following final enactment.

35.4 (b) Clauses (21) to (24) are effective upon federal approval. The commissioner of human
 35.5 services shall notify the revisor of statutes when federal approval is obtained.

35.6 Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

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

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

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

35.19 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
 35.20 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
 35.21 (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code
 35.22 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
 35.23 29-2053); and 20 percent of the median wage for social and human services aide (SOC code
 35.24 21-1093);

35.25 (2) for day services, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code
 35.26 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
 35.27 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
 35.28 21-1093);

35.29 (3) for residential asleep-overnight staff, the wage ~~will be \$7.66 per hour~~ is the minimum
 35.30 wage in Minnesota for large employers, except in a family foster care setting, the wage is
 35.31 ~~\$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

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

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

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

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

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

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

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

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

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

36.29 ~~(11)~~ (13) for supported employment support services staff, 20 ~~50~~ percent of the median
36.30 wage for nursing aide rehabilitation counselor (SOC code ~~31-1012~~ 21-1015); 20 percent of
36.31 ~~the median wage for psychiatric technician (SOC code 29-2053); and 60~~ 50 percent of the
36.32 median wage for community and social and human services aide specialist (SOC code
36.33 ~~21-1093~~ 21-1099);

37.1 (14) for employment exploration services staff, 50 percent of the median wage for
 37.2 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
 37.3 community and social services specialist (SOC code 21-1099);

37.4 (15) for employment development services staff, 50 percent of the median wage for
 37.5 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
 37.6 of the median wage for community and social services specialist (SOC code 21-1099);

37.7 ~~(12)~~ (16) for adult companion staff, 50 percent of the median wage for personal and
 37.8 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
 37.9 ~~orderlies, and attendants~~ assistant (SOC code 31-1012 31-1014);

37.10 ~~(13)~~ (17) for night supervision staff, 20 percent of the median wage for home health
 37.11 aide (SOC code 31-1011); 20 percent of the median wage for personal and home health
 37.12 aide (SOC code 39-9021); 20 percent of the median wage for nursing aide assistant (SOC
 37.13 code 31-1012 31-1014); 20 percent of the median wage for psychiatric technician (SOC
 37.14 code 29-2053); and 20 percent of the median wage for social and human services aide (SOC
 37.15 code 21-1093);

37.16 ~~(14)~~ (18) for respite staff, 50 percent of the median wage for personal and home care
 37.17 aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies,
 37.18 ~~and attendants~~ assistant (SOC code 31-1012 31-1014);

37.19 ~~(15)~~ (19) for personal support staff, 50 percent of the median wage for personal and
 37.20 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
 37.21 ~~orderlies, and attendants~~ assistant (SOC code 31-1012 31-1014);

37.22 ~~(16)~~ (20) for supervisory staff, the basic wage is \$17.43 per hour, 100 percent of the
 37.23 median wage for community and social services specialist (SOC code 21-1099), with the
 37.24 exception of the supervisor of behavior professional, behavior analyst, and behavior
 37.25 specialists, which must be \$30.75 per hour is 100 percent of the median wage for clinical
 37.26 counseling and school psychologist (SOC code 19-3031);

37.27 ~~(17)~~ (21) for registered nurse staff, the basic wage is \$30.82 per hour, 100 percent of
 37.28 the median wage for registered nurses (SOC code 29-1141); and

37.29 ~~(18)~~ (22) for licensed practical nurse staff, the basic wage is \$18.64 per hour 100 percent
 37.30 of the median wage for licensed practical nurses (SOC code 29-2061).

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

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

- 38.1 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 38.2 (3) employee-related cost ratio: 23.6 percent;
- 38.3 (4) general administrative support ratio: 13.25 percent;
- 38.4 (5) program-related expense ratio: 1.3 percent; and
- 38.5 (6) absence and utilization factor ratio: 3.9 percent.
- 38.6 (c) Component values for family foster care are:
- 38.7 (1) supervisory span of control ratio: 11 percent;
- 38.8 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 38.9 (3) employee-related cost ratio: 23.6 percent;
- 38.10 (4) general administrative support ratio: 3.3 percent;
- 38.11 (5) program-related expense ratio: 1.3 percent; and
- 38.12 (6) absence factor: 1.7 percent.
- 38.13 (d) Component values for day services for all services are:
- 38.14 (1) supervisory span of control ratio: 11 percent;
- 38.15 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 38.16 (3) employee-related cost ratio: 23.6 percent;
- 38.17 (4) program plan support ratio: 5.6 percent;
- 38.18 (5) client programming and support ratio: ten percent;
- 38.19 (6) general administrative support ratio: 13.25 percent;
- 38.20 (7) program-related expense ratio: 1.8 percent; and
- 38.21 (8) absence and utilization factor ratio: ~~3.9~~ 9.4 percent.
- 38.22 (e) Component values for unit-based services with programming are:
- 38.23 (1) supervisory span of control ratio: 11 percent;
- 38.24 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 38.25 (3) employee-related cost ratio: 23.6 percent;
- 38.26 (4) program plan supports ratio: ~~3.4~~ 15.5 percent;
- 38.27 (5) client programming and supports ratio: ~~8.6~~ 4.7 percent;

- 39.1 (6) general administrative support ratio: 13.25 percent;
- 39.2 (7) program-related expense ratio: 6.1 percent; and
- 39.3 (8) absence and utilization factor ratio: 3.9 percent.
- 39.4 (f) Component values for unit-based services without programming except respite are:
- 39.5 (1) supervisory span of control ratio: 11 percent;
- 39.6 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 39.7 (3) employee-related cost ratio: 23.6 percent;
- 39.8 (4) program plan support ratio: ~~3.4~~ 7.0 percent;
- 39.9 (5) client programming and support ratio: ~~8.6~~ 2.3 percent;
- 39.10 (6) general administrative support ratio: 13.25 percent;
- 39.11 (7) program-related expense ratio: ~~6.4~~ 2.9 percent; and
- 39.12 (8) absence and utilization factor ratio: 3.9 percent.
- 39.13 (g) Component values for unit-based services without programming for respite are:
- 39.14 (1) supervisory span of control ratio: 11 percent;
- 39.15 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 39.16 (3) employee-related cost ratio: 23.6 percent;
- 39.17 (4) general administrative support ratio: 13.25 percent;
- 39.18 (5) program-related expense ratio: ~~6.4~~ 2.9 percent; and
- 39.19 (6) absence and utilization factor ratio: 3.9 percent.
- 39.20 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
- 39.21 (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor
- 39.22 Statistics available on December 31, 2016. The commissioner shall publish these updated
- 39.23 values and load them into the rate management system. ~~This adjustment occurs every five~~
- 39.24 ~~years. For adjustments in 2021 and beyond, the commissioner shall use the data available~~
- 39.25 ~~on December 31 of the calendar year five years prior.~~ On January 1, 2022, and every two
- 39.26 years thereafter, the commissioner shall update the base wage index in paragraph (a) based
- 39.27 on the most recently available wage data by SOC from the Bureau of Labor Statistics. The
- 39.28 commissioner shall publish these updated values and load them into the rate management
- 39.29 system.

40.1 (i) On July 1, 2017, the commissioner shall update the framework components in
40.2 ~~paragraphs (b) to (g)~~ paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f),
40.3 clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17),
40.4 for changes in the Consumer Price Index. The commissioner will adjust these values higher
40.5 or lower by the percentage change in the Consumer Price Index-All Items, United States
40.6 city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall
40.7 publish these updated values and load them into the rate management system. ~~This adjustment~~
40.8 ~~occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use~~
40.9 ~~the data available on January 1 of the calendar year four years prior and January 1 of the~~
40.10 ~~current calendar year. On January 1, 2022, and every two years thereafter, the commissioner~~
40.11 shall update the framework components in paragraph (d), clause (5); paragraph (e), clause
40.12 (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7,
40.13 clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner
40.14 shall adjust these values higher or lower by the percentage change in the CPI-U from the
40.15 date of the previous update to the date of the data most recently available prior to the
40.16 scheduled update. The commissioner shall publish these updated values and load them into
40.17 the rate management system.

40.18 (j) If Bureau of Labor Statistics SOC or Consumer Price Index items are unavailable in
40.19 the future, the commissioner shall recommend to the legislature codes or items to update
40.20 and replace missing component values.

40.21 (k) The commissioner must ensure that wage values and component values in subdivisions
40.22 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in
40.23 consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider
40.24 enrolled to provide services with rates determined under this section must submit business
40.25 cost data to the commissioner to support research on the cost of providing services that have
40.26 rates determined by the disability waiver rates system. Required business cost data includes,
40.27 but is not limited to:

40.28 (1) worker wage costs;

40.29 (2) benefits paid;

40.30 (3) supervisor wage costs;

40.31 (4) executive wage costs;

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

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

41.1 (7) administrative costs paid;

41.2 (8) program costs paid;

41.3 (9) transportation costs paid;

41.4 (10) vacancy rates; and

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

41.7 (l) A provider must submit cost component data at least once in any five-year period,
41.8 on a schedule determined by the commissioner, in consultation with stakeholders identified
41.9 in section 256B.4913, subdivision 5. If a provider fails to submit required reporting data,
41.10 the commissioner shall provide notice to providers that have not provided required data 30
41.11 days after the required submission date, and a second notice for providers who have not
41.12 provided required data 60 days after the required submission date. The commissioner shall
41.13 temporarily suspend payments to the provider if cost component data is not received 90
41.14 days after the required submission date. Withheld payments shall be made once data is
41.15 received by the commissioner.

41.16 (m) The commissioner shall conduct a random audit of data submitted under paragraph
41.17 (k) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph
41.18 (k) and provide recommendations for adjustments to cost components.

41.19 (n) The commissioner shall analyze cost documentation in paragraph (k) and, in
41.20 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
41.21 recommendations on component values and inflationary factor adjustments to the chairs
41.22 and ranking minority members of the legislative committees with jurisdiction over human
41.23 services every four years beginning January 1, 2020. The commissioner shall make
41.24 recommendations in conjunction with reports submitted to the legislature according to
41.25 subdivision 10, paragraph (e). The commissioner shall release business cost data in an
41.26 aggregate form, and business cost data from individual providers shall not be released except
41.27 as provided for in current law.

41.28 (o) The commissioner, in consultation with stakeholders identified in section 256B.4913,
41.29 subdivision 5, shall develop and implement a process for providing training and technical
41.30 assistance necessary to support provider submission of cost documentation required under
41.31 paragraph (k).

41.32 **EFFECTIVE DATE.** (a) The amendments to paragraphs (a) to (g) are effective January
41.33 1, 2018, except the amendment to paragraph (d), clause (8), which is effective January 1,

42.1 2019, and the amendment to paragraph (a), clause (10), which is effective the day following
42.2 final enactment.

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

42.5 Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

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

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

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

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

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

42.20 (5) multiply the number of shared and individual direct staff hours provided on site or
42.21 through monitoring technology and nursing hours by the product of the supervision span
42.22 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
42.23 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

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

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

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

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

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

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

43.17 (d) For individuals enrolled prior to January 1, 2014, the days of service authorized must
43.18 meet or exceed the days of service used to convert service agreements in effect on December
43.19 1, 2013, and must not result in a reduction in spending or service utilization due to conversion
43.20 during the implementation period under section 256B.4913, subdivision 4a. If during the
43.21 implementation period, an individual's historical rate, including adjustments required under
43.22 section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate
43.23 determined in this subdivision, the number of days authorized for the individual is 365.

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

43.26 Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:

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

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

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

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

44.3 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
44.4 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
44.5 5;

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

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

44.11 (5) multiply the number of day direct staff hours by the product of the supervision span
44.12 of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision
44.13 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

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

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

44.26 (12) this is the subtotal rate;

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

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

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

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

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

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

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

45.14 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
45.15 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
45.16 with a lift;

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

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

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

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

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

45.27 Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

45.28 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
45.29 services with programming, including behavior programming, housing access coordination,
45.30 in-home family support, independent living skills training, independent living skills specialist
45.31 services, individualized home supports, hourly supported living services, employment
45.32 exploration services, employment development services, and supported employment support

46.1 services provided to an individual outside of any day or residential service plan must be
46.2 calculated as follows, unless the services are authorized separately under subdivision 6 or
46.3 7:

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

46.5 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
46.6 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
46.7 5;

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

46.11 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
46.12 5, paragraph (a), or the customized direct-care rate;

46.13 (5) multiply the number of direct staff hours by the product of the supervision span of
46.14 control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
46.15 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

46.25 (10) this is the subtotal rate;

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

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

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

47.1 in a shared manner, divide the total payment amount in clause (12) by the number of service
47.2 recipients, not to exceed two; and

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

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

47.6 Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

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

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

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

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

47.19 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
47.20 5 or the customized direct care rate;

47.21 (5) multiply the number of direct staff hours by the product of the supervision span of
47.22 control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
47.23 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

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

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

48.3 (10) this is the subtotal rate;

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

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

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

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

48.12 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
48.13 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
48.14 is defined as the customized direct care rate;

48.15 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
48.16 5, paragraph (a);

48.17 (17) multiply the number of direct staff hours by the product of the supervisory span of
48.18 control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
48.19 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

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

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

48.25 (20) this is the subtotal rate;

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

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

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

49.1 Sec. 27. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

49.2 Subd. 10. **Updating payment values and additional information.** (a) From January
49.3 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform
49.4 procedures to refine terms and adjust values used to calculate payment rates in this section.

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

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

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

49.12 (3) the distinct underlying costs for services provided by a license holder under sections
49.13 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
49.14 by a license holder certified under section 245D.33.

49.15 (c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid
49.16 set of rates management system data, the commissioner, in consultation with stakeholders,
49.17 shall analyze for each service the average difference in the rate on December 31, 2013, and
49.18 the framework rate at the individual, provider, lead agency, and state levels. The
49.19 commissioner shall issue semiannual reports to the stakeholders on the difference in rates
49.20 by service and by county during the banding period under section 256B.4913, subdivision
49.21 4a. The commissioner shall issue the first report by October 1, 2014, and the final report
49.22 shall be issued by December 31, 2018.

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

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

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

49.28 ~~(3)~~ (2) values for services where monitoring technology replaces staff time;

49.29 ~~(4)~~ (3) values for indirect services;

49.30 ~~(5)~~ (4) values for nursing;

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

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

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

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

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

50.5 ~~(11)~~ (5) values for the facility use rate in day services, and the weightings used in the
50.6 day service ratios and adjustments to those weightings;

50.7 ~~(12)~~ (6) values for workers' compensation as part of employee-related expenses;

50.8 ~~(13)~~ (7) values for unemployment insurance as part of employee-related expenses;

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

50.12 ~~(15)~~ (8) any changes in state or federal law with ~~an~~ a direct impact on the underlying
50.13 cost of providing home and community-based services; and

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

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

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

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

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

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

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

51.1 ~~(g)~~ (f) The commissioner shall implement a regional adjustment factor to all rate
 51.2 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July
 51.3 1, 2017, the commissioner shall renew analysis and implement changes to the regional
 51.4 adjustment factors when adjustments required under subdivision 5, paragraph (h), occur.
 51.5 Prior to implementation, the commissioner shall consult with stakeholders on the
 51.6 methodology to calculate the adjustment.

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

51.10 (1) calculation values including derived wage rates and related employee and
 51.11 administrative factors;

51.12 (2) service utilization;

51.13 (3) county and tribal allocation changes; and

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

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

51.17 ~~(i) No later than July 1, 2016, the commissioner shall develop and implement, in~~
 51.18 ~~consultation with stakeholders, a methodology sufficient to determine the shared staffing~~
 51.19 ~~levels necessary to meet, at a minimum, health and welfare needs of individuals who will~~
 51.20 ~~be living together in shared residential settings, and the required shared staffing activities~~
 51.21 ~~described in subdivision 2, paragraph (1). This determination methodology must ensure~~
 51.22 ~~staffing levels are adaptable to meet the needs and desired outcomes for current and~~
 51.23 ~~prospective residents in shared residential settings.~~

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

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

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

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

52.4 Sec. 28. Minnesota Statutes 2016, section 256B.85, subdivision 3, is amended to read:

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

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

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

52.9 (3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or
 52.10 256B.49; or

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

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

52.15 (1) require assistance and be determined dependent in one activity of daily living or
 52.16 Level I behavior based on an initial assessment under section 256B.0911, subdivision 3a,
 52.17 a reassessment under section 256B.0911, subdivision 3g, or an annual service update under
 52.18 section 256B.0911, subdivision 3f; and

52.19 (2) is not a participant under a family support grant under section 252.32.

52.20 Sec. 29. Minnesota Statutes 2016, section 256B.85, subdivision 5, is amended to read:

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

52.22 (1) be conducted by a certified assessor according to the criteria established in section
 52.23 256B.0911, subdivision 3a;

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

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

52.29 (b) The results of the assessment and any recommendations and authorizations for CFSS
 52.30 must be determined and communicated in writing by the lead agency's certified assessor as

53.1 defined in section 256B.0911 to the participant and the agency-provider or FMS provider
 53.2 chosen by the participant within 40 calendar days and must include the participant's right
 53.3 to appeal under section 256.045, subdivision 3.

53.4 (c) The lead agency assessor may authorize a temporary authorization for CFSS services
 53.5 to be provided under the agency-provider model. Authorization for a temporary level of
 53.6 CFSS services under the agency-provider model is limited to the time specified by the
 53.7 commissioner, but shall not exceed 45 days. The level of services authorized under this
 53.8 paragraph shall have no bearing on a future authorization. Participants approved for a
 53.9 temporary authorization shall access the consultation service to complete their orientation
 53.10 and selection of a service model.

53.11 Sec. 30. Minnesota Statutes 2016, section 256B.85, subdivision 6, is amended to read:

53.12 Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS
 53.13 service delivery plan must be developed and evaluated through a person-centered planning
 53.14 process by the participant, or the participant's representative or legal representative who
 53.15 may be assisted by a consultation services provider. The CFSS service delivery plan must
 53.16 reflect the services and supports that are important to the participant and for the participant
 53.17 to meet the needs assessed by the certified assessor and identified in the coordinated service
 53.18 and support plan identified in section 256B.0915, subdivision 6. The CFSS service delivery
 53.19 plan must be reviewed by the participant, the consultation services provider, and the
 53.20 agency-provider or FMS provider prior to starting services and ~~at least annually upon~~
 53.21 ~~reassessment, or~~ as necessary when there is a significant change in the participant's condition,
 53.22 or a change in the need for services and supports, or at the request of the participant or the
 53.23 participant's representative.

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

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

53.27 (1) specify the consultation services provider, agency-provider, or FMS provider selected
 53.28 by the participant;

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

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

53.31 (4) include the methods and supports used to address the needs as identified through an
 53.32 assessment of functional needs;

- 54.1 (5) include the participant's identified goals and desired outcomes;
- 54.2 (6) reflect the services and supports, paid and unpaid, that will assist the participant to
54.3 achieve identified goals, including the costs of the services and supports, and the providers
54.4 of those services and supports, including natural supports;
- 54.5 (7) identify the amount and frequency of face-to-face supports and amount and frequency
54.6 of remote supports and technology that will be used;
- 54.7 (8) identify risk factors and measures in place to minimize them, including individualized
54.8 backup plans;
- 54.9 (9) be understandable to the participant and the individuals providing support;
- 54.10 (10) identify the individual or entity responsible for monitoring the plan;
- 54.11 (11) be finalized and agreed to in writing by the participant and signed by all individuals
54.12 and providers responsible for its implementation;
- 54.13 (12) be distributed to the participant and other people involved in the plan;
- 54.14 (13) prevent the provision of unnecessary or inappropriate care;
- 54.15 (14) include a detailed budget for expenditures for budget model participants or
54.16 participants under the agency-provider model if purchasing goods; and
- 54.17 (15) include a plan for worker training and development provided according to
54.18 subdivision 18a detailing what service components will be used, when the service components
54.19 will be used, how they will be provided, and how these service components relate to the
54.20 participant's individual needs and CFSS support worker services.
- 54.21 (d) The total units of agency-provider services or the service budget amount for the
54.22 budget model include both annual totals and a monthly average amount that cover the
54.23 number of months of the service agreement. The amount used each month may vary, but
54.24 additional funds must not be provided above the annual service authorization amount,
54.25 determined according to subdivision 8, unless a change in condition is assessed and
54.26 authorized by the certified assessor and documented in the coordinated service and support
54.27 plan and CFSS service delivery plan.
- 54.28 (e) In assisting with the development or modification of the CFSS service delivery plan
54.29 during the authorization time period, the consultation services provider shall:
- 54.30 (1) consult with the FMS provider on the spending budget when applicable; and

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

55.3 (f) The CFSS service delivery plan must be approved by the consultation services provider
55.4 for participants without a case manager or care coordinator who is responsible for authorizing
55.5 services. A case manager or care coordinator must approve the plan for a waiver or alternative
55.6 care program participant.

55.7 Sec. 31. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
55.8 to read:

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

55.12 Sec. 32. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

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

55.17 Sec. 33. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
55.18 to read:

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

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

55.22 (2) interpreting between a spoken language and a visual representation of a spoken
55.23 language, such as cued speech and signing systems in English;

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

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

55.29 (5) interpreting between one communication mode or language into another
55.30 communication mode or language that is linguistically and culturally appropriate for the
55.31 participants in the communication exchange.

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

56.3 Subd. 6. **Real-time captioning.** "Real-time captioning" means a method of captioning
56.4 in which a caption is simultaneously prepared and displayed or transmitted at the time of
56.5 origination by specially trained real-time captioners.

56.6 Sec. 35. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

56.7 Subdivision 1. **Deaf and Hard-of-Hearing Services Division.** The commissioners of
56.8 ~~human services, education, employment and economic development, and health shall create~~
56.9 ~~a distinct and separate organizational unit to be known as~~ advise the commissioner of human
56.10 services on the activities of the Deaf and Hard-of-Hearing Services Division to address.
56.11 This division addresses the developmental, social, educational, and occupational and
56.12 social-emotional needs of persons who are deaf, persons who are deafblind, and persons
56.13 who are hard-of-hearing persons through a statewide network of collaborative services and
56.14 by coordinating the promulgation of public policies, regulations, legislation, and programs
56.15 affecting advocates on behalf of and provides information and training about how to best
56.16 serve persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing
56.17 persons. An interdepartmental management team shall advise the activities of the Deaf and
56.18 ~~Hard-of-Hearing Services Division.~~ The commissioner of human services shall coordinate
56.19 the work of the interagency ~~management team~~ advisers and receive legislative appropriations
56.20 for the division.

56.21 Sec. 36. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

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

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

56.26 (2) assist work across divisions within the Departments Department of Human Services,
56.27 Education, and Employment and Economic Development to coordinate the promulgation
56.28 and implementation of public policies, regulations, legislation, programs, and services
56.29 affecting as well as with other agencies and counties, to ensure that there is an understanding
56.30 of:

56.31 (i) the communication challenges faced by persons who are deaf, persons who are
56.32 deafblind, and persons who are hard-of-hearing persons;

57.1 (ii) the best practices for accommodating and mitigating communication challenges;

57.2 and

57.3 (iii) the legal requirements for providing access to and effective communication with

57.4 persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing; and

57.5 (3) ~~provide a coordinated system of~~ assess the supply and demand statewide interpreting

57.6 ~~or~~ for interpreter referral services; and real-time captioning services, implement strategies

57.7 to provide greater access to these services in areas without sufficient supply, and build the

57.8 base of service providers across the state;

57.9 (4) maintain a statewide information resource that includes contact information and

57.10 professional certification credentials of interpreting service providers and real-time captioning

57.11 service providers;

57.12 (5) provide culturally affirmative mental health services to persons who are deaf, persons

57.13 who are hard-of-hearing, and persons who are deafblind, who:

57.14 (i) use a visual language such as American Sign Language or a tactile form of a language;

57.15 or

57.16 (ii) otherwise need culturally affirmative therapeutic services;

57.17 (6) research and develop best practices and recommendations for emerging issues;

57.18 (7) provide as much information as practicable on the division's stand-alone Web site

57.19 in American Sign Language; and

57.20 (8) report to the chairs and ranking minority members of the legislative committees with

57.21 jurisdiction over human services biennially, beginning on January 1, 2019, on the following:

57.22 (i) the number of regional service center staff, the location of the office of each staff

57.23 person, other service providers with which they are colocated, the number of people served

57.24 by each staff person, and a breakdown of whether each person was served on-site or off-site,

57.25 and for those served off-site, a list of locations where services were delivered, and the

57.26 number who were served in-person and the number who were served via technology;

57.27 (ii) the amount and percentage of the division budget spent on reasonable

57.28 accommodations for staff;

57.29 (iii) the number of people who use demonstration equipment and consumer evaluations

57.30 of the experience;

58.1 (iv) the number of training sessions provided by division staff, the topics covered, the
 58.2 number of participants, and consumer evaluations, including a breakdown by delivery
 58.3 method such as in-person or via technology;

58.4 (v) the number of training sessions hosted at a division location provided by another
 58.5 service provider, the topics covered, the number of participants, and consumer evaluations,
 58.6 including a breakdown by delivery method such as in-person or via technology;

58.7 (vi) for each grant awarded, the amount awarded to the grantee and a summary of the
 58.8 grantee's results, including consumer evaluations of the services or products provided;

58.9 (vii) the number of people on waiting lists for any services provided by division staff
 58.10 or for services or equipment funded through grants awarded by the division;

58.11 (viii) the amount of time staff spent driving to appointments to deliver direct one-to-one
 58.12 client services in locations outside of the regional service centers;

58.13 (ix) the amount spent on mileage reimbursement and the number of clients who received
 58.14 mileage reimbursement for traveling to the regional service centers for services; and

58.15 (x) the regional needs and feedback on addressing service gaps identified by the advisory
 58.16 committee.

58.17 Sec. 37. Minnesota Statutes 2016, section 256C.24, subdivision 1, is amended to read:

58.18 Subdivision 1. **Location.** The Deaf and Hard-of-Hearing Services Division shall establish
 58.19 ~~up to eight~~ at least six regional service centers for persons who are deaf and persons who
 58.20 are hard-of-hearing persons. The centers shall be distributed regionally to provide access
 58.21 for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing
 58.22 persons in all parts of the state.

58.23 Sec. 38. Minnesota Statutes 2016, section 256C.24, subdivision 2, is amended to read:

58.24 Subd. 2. **Responsibilities.** Each regional service center shall:

58.25 ~~(1) serve as a central entry point for~~ (1) establish connections and collaborations colocating
 58.26 with other public and private entities providing services to persons who are deaf, persons
 58.27 who are deafblind, and persons who are hard-of-hearing persons in need of services and
 58.28 ~~make referrals to the services needed~~ in the region;

58.29 (2) for those in need of services, assist in coordinating services between service providers
 58.30 and persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing,
 58.31 and the persons' families, and make referrals to the services needed;

59.1 ~~(2)~~ (3) employ staff trained to work with persons who are deaf, persons who are deafblind,
 59.2 and persons who are hard-of-hearing persons;

59.3 ~~(3)~~ (4) if adequate services are not available from another public or private service
 59.4 provider in the region, provide to all individual assistance to persons who are deaf, persons
 59.5 who are deafblind, and persons who are hard-of-hearing persons access to interpreter services
 59.6 which are necessary to help them obtain services, and the persons' families. Individual
 59.7 culturally affirmative assistance may be provided using technology only in areas of the state
 59.8 when a person has access to sufficient quality telecommunications or broadband services
 59.9 to allow effective communication. When a person who is deaf, a person who is deafblind,
 59.10 or a person who is hard-of-hearing does not have access to sufficient telecommunications
 59.11 or broadband service, individual assistance shall be available in person;

59.12 (5) identify regional training needs, work with deaf and hard-of-hearing services training
 59.13 staff, and collaborate with others to deliver training for persons who are deaf, persons who
 59.14 are deafblind, and persons who are hard-of-hearing, and the persons' families, and other
 59.15 service providers about subjects including the persons' rights under the law, American Sign
 59.16 Language, and the impact of hearing loss and options for accommodating it;

59.17 ~~(4) implement a plan to provide loaned equipment and resource materials to deaf,~~
 59.18 ~~deafblind, and hard-of-hearing~~ (6) have a mobile or permanent lab where persons who are
 59.19 deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection
 59.20 of modern assistive technology and equipment to determine what would best meet the
 59.21 persons' needs;

59.22 ~~(5) cooperate with responsible departments and administrative authorities to provide~~
 59.23 ~~access for deaf, deafblind, and hard-of-hearing persons to services provided by state, county,~~
 59.24 ~~and regional agencies;~~

59.25 ~~(6)~~ (7) collaborate with the Resource Center for the Deaf and Hard-of-Hearing Persons,
 59.26 other divisions of the Department of Education, and local school districts to develop and
 59.27 deliver programs and services for families with children who are deaf, children who are
 59.28 deafblind, or children who are hard-of-hearing children and to support school personnel
 59.29 serving these children;

59.30 ~~(7) when possible,~~ (8) provide training to the social service or income maintenance staff
 59.31 employed by counties or by organizations with whom counties contract for services to
 59.32 ensure that communication barriers which prevent persons who are deaf, persons who are
 59.33 deafblind, and persons who are hard-of-hearing persons from using services are removed;

60.1 ~~(8) when possible, (9)~~ provide training to ~~state and regional~~ human service agencies in
 60.2 the region regarding program access for persons who are deaf, persons who are deafblind,
 60.3 and persons who are hard-of-hearing persons; and

60.4 ~~(9) (10)~~ assess the ongoing need and supply of services for persons who are deaf, persons
 60.5 who are deafblind, and persons who are hard-of-hearing persons in all parts of the state,
 60.6 annually consult with the division's advisory committees to identify regional needs and
 60.7 solicit feedback on addressing service gaps, and cooperate with public and private service
 60.8 providers to develop these services;

60.9 (11) provide culturally affirmative mental health services to persons who are deaf,
 60.10 persons who are hard-of-hearing, and persons who are deafblind, who:

60.11 (i) use a visual language such as American Sign Language or a tactile form of a language;
 60.12 or

60.13 (ii) otherwise need culturally affirmative therapeutic services; and

60.14 (12) establish partnerships with state and regional entities statewide with the technological
 60.15 capacity to provide Minnesotans with virtual access to the division's services and
 60.16 division-sponsored training via technology.

60.17 Sec. 39. Minnesota Statutes 2016, section 256C.24, is amended by adding a subdivision
 60.18 to read:

60.19 Subd. 4. **Transportation cost reimbursement.** Persons who are deaf, persons who are
 60.20 deafblind, and persons who are hard-of-hearing, and the person's family members who
 60.21 travel more than 50 miles round-trip from the person's home or work location to receive
 60.22 services at the regional service center may be reimbursed by the Deaf and Hard-of-Hearing
 60.23 Division for mileage at the reimbursement rate established by the Internal Revenue Service.

60.24 Sec. 40. Minnesota Statutes 2016, section 256C.261, is amended to read:

60.25 **256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND PERSONS.**

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

61.1 use at least 25 percent of the deafblind services biennial base level grant funding for services
 61.2 and other supports for an adult who is deafblind.

61.3 The commissioner shall award grants for the purposes of:

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

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

61.10 (b) The commissioner may make grants:

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

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

61.13 (c) Consumer-directed services shall be provided in whole by grant-funded providers.

61.14 The deaf and hard-of-hearing regional service centers shall not provide any aspect of a
 61.15 grant-funded consumer-directed services program.

61.16 ~~(e)~~ (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant
 61.17 under paragraph (a).

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

61.20 Sec. 41. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
 61.21 **METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND**
 61.22 **CRISIS RESIDENTIAL SETTINGS.**

61.23 (a) By September 30, 2017, the commissioner shall establish an institutional and crisis
 61.24 bed consumer-directed community supports budget exception process in the home and
 61.25 community-based services waivers under Minnesota Statutes, sections 256B.092 and
 61.26 256B.49. This budget exception process shall be available for any individual who:

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

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

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

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

62.9 **Sec. 42. FEDERAL WAIVER REQUESTS.**

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

62.17 **EFFECTIVE DATE.** This section is effective August 1, 2017.

62.18 **Sec. 43. TRANSPORTATION STUDY.**

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

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

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

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

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

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

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

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

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

63.8 Sec. 44. **DIRECTION TO COMMISSIONER; TELECOMMUNICATION**

63.9 **EQUIPMENT PROGRAM.**

63.10 (a) The commissioner of human services shall work in consultation with the Commission
 63.11 of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by
 63.12 January 15, 2018, to the chairs and ranking minority members of the house of representatives
 63.13 and senate committees with jurisdiction over human services to modernize the
 63.14 telecommunication equipment program. The recommendations must address:

63.15 (1) types of equipment and supports the program should provide to ensure people with
 63.16 communication difficulties have equitable access to telecommunications services;

63.17 (2) additional services the program should provide such as education about technology
 63.18 options that can improve a person's access to telecommunications service; and

63.19 (3) how the current program's service delivery structure might be improved to better
 63.20 meet the needs of people with communication disabilities.

63.21 (b) The commissioner shall also provide draft legislative language to accomplish the
 63.22 recommendations. Final recommendations, the final report, and draft legislative language
 63.23 must be approved by both the commissioner and the chair of the commission.

63.24 Sec. 45. **DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH**
 63.25 **SERVICES.**

63.26 By January 1, 2018, the commissioner of human services shall report to the chairs and
 63.27 ranking minority members of the house of representatives and senate committees with
 63.28 jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the
 63.29 Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health
 63.30 services.

64.1 Sec. 46. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES.**

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

64.5 (1) reduce assessment times;

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

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

64.11 (4) evaluate alternative payment methods.

64.12 Sec. 47. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS**
64.13 **BUDGET METHODOLOGY EXCEPTION.**

64.14 (a) No later than September 30, 2017, if necessary, the commissioner of human services
64.15 shall submit an amendment to the Centers for Medicare and Medicaid Services for the home
64.16 and community-based services waivers authorized under Minnesota Statutes, sections
64.17 256B.092 and 256B.49, to expand the exception to the consumer-directed community
64.18 supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to increase
64.19 consumer-directed community support budgets up to 30 percent for the following:

64.20 (1) consumer-directed community support participants whose current consumer-directed
64.21 community support budget cannot accommodate increased services and supports identified
64.22 in the participant's coordinated service and support plan and that are required in order to:

64.23 (i) increase the amount of time a participant works or otherwise improves employment
64.24 opportunity;

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

64.27 (iii) develop and implement a positive support plan; or

64.28 (2) home and community-based waiver participants who are currently using licensed
64.29 providers for residential services that cost more annually than the participant would spend
64.30 under a consumer-directed community support plan for any and all of the services and
64.31 supports needed to meet the goals identified in clause (1).

65.1 (b) The exception under paragraph (a), clause (1), is limited to those consumer-directed
 65.2 community participants who can demonstrate that the participant shall discontinue
 65.3 consumer-directed community supports and accept other nonself-directed waiver services
 65.4 because the participant cannot meet the goals described in paragraph (a), clause (1), within
 65.5 the participant's current consumer-directed community support budget limits.

65.6 (c) The exception under paragraph (a), clause (2), is limited to those home and
 65.7 community-based waiver participants who can demonstrate that, upon choosing to become
 65.8 a consumer-directed community support participant, the total cost of services, including the
 65.9 exception, would be less than the cost of the waiver services the participant would otherwise
 65.10 receive.

65.11 Sec. 48. **REPEALER.**

65.12 Minnesota Statutes 2016, sections 256B.4914, subdivision 16; 256C.23, subdivision 3;
 65.13 256C.233, subdivision 4; and 256C.25, subdivisions 1 and 2, are repealed.

65.14 **ARTICLE 2**

65.15 **HOUSING**

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

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

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

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

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

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

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

65.31 (6) the term of the contract;

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

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

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

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

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

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

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

66.16 (14) billing and payment procedures and requirements;

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

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

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

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

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

66.27 **Subd. 2a. Additional contract requirements.** (a) For a resident receiving one or more
 66.28 health-related services from the establishment's arranged home care provider, as defined in
 66.29 section 144D.01, subdivision 6, the contract must include the requirements in paragraph
 66.30 (b). A restriction of a resident's rights under this subdivision is allowed only if determined
 66.31 necessary for health and safety reasons identified by the home care provider's registered

67.1 nurse in an initial assessment or reassessment, as defined under section 144A.4791,
 67.2 subdivision 8, and documented in the written service plan under section 144A.4791,
 67.3 subdivision 9. Any restrictions of those rights for people served under sections 256B.0915
 67.4 and 256B.49 must be documented in the resident's coordinated service and support plan
 67.5 (CSSP), as defined under sections 256B.0915, subdivision 6 and 256B.49, subdivision 15.

67.6 (b) The contract must include a statement:

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

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

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

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

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

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

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

67.18 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
 67.19 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
 67.20 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
 67.21 for a physical location that will not be the primary residence of the license holder for the
 67.22 entire period of licensure. If a license is issued during this moratorium, and the license
 67.23 holder changes the license holder's primary residence away from the physical location of
 67.24 the foster care license, the commissioner shall revoke the license according to section
 67.25 245A.07. The commissioner shall not issue an initial license for a community residential
 67.26 setting licensed under chapter 245D. Exceptions to the moratorium include:

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

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

67.31 (b);

68.1 (3) new foster care licenses or community residential setting licenses determined to be
68.2 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
68.3 or regional treatment center; restructuring of state-operated services that limits the capacity
68.4 of state-operated facilities; or allowing movement to the community for people who no
68.5 longer require the level of care provided in state-operated facilities as provided under section
68.6 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

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

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

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

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

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

69.1 reconsideration is final and not subject to appeal under chapter 14. The exception is available
69.2 until June 30, 2018. This exception is available when:

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

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

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

69.15 (c) When an adult resident served by the program moves out of a foster home that is not
69.16 the primary residence of the license holder according to section 256B.49, subdivision 15,
69.17 paragraph (f), or the adult community residential setting, the county shall immediately
69.18 inform the Department of Human Services Licensing Division. The department ~~shall~~ may
69.19 decrease the statewide licensed capacity for adult foster care settings ~~where the physical~~
69.20 ~~location is not the primary residence of the license holder, or for adult community residential~~
69.21 ~~settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the~~
69.22 ~~savings required by reductions in licensed bed capacity under Laws 2011, First Special~~
69.23 ~~Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term~~
69.24 ~~care residential services capacity within budgetary limits. Implementation of the statewide~~
69.25 ~~licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense~~
69.26 ~~up to 128 beds by June 30, 2014, using the needs determination process. Prior to any~~
69.27 ~~involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies~~
69.28 ~~and license holders to determine which adult foster care settings, where the physical location~~
69.29 ~~is not the primary residence of the license holder, or community residential settings, are~~
69.30 ~~licensed for up to five beds, but have operated at less than full capacity for 12 or more~~
69.31 ~~months as of March 1, 2014. The settings that meet these criteria must be the first to be~~
69.32 ~~considered for an involuntary decrease in statewide licensed capacity, up to a maximum of~~
69.33 ~~35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall~~
69.34 ~~prioritize the selection of those beds to be closed based on the length of time the beds have~~
69.35 ~~been vacant. The longer a bed has been vacant, the higher priority it must be given for~~

70.1 ~~closure. Under this paragraph, the commissioner has the authority to reduce unused licensed~~
70.2 ~~capacity of a current foster care program, or the community residential settings, to accomplish~~
70.3 ~~the consolidation or closure of settings. Under this paragraph, the commissioner has the~~
70.4 ~~authority to manage statewide capacity, including adjusting the capacity available to each~~
70.5 ~~county and adjusting statewide available capacity, to meet the statewide needs identified~~
70.6 ~~through the process in paragraph (e). A decreased licensed capacity according to this~~
70.7 ~~paragraph is not subject to appeal under this chapter.~~

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

70.12 (e) A resource need determination process, managed at the state level, using the available
70.13 reports required by section 144A.351, and other data and information shall be used to
70.14 determine where the reduced capacity ~~required~~ determined under ~~paragraph (e)~~ section
70.15 256B.493 will be implemented. The commissioner shall consult with the stakeholders
70.16 described in section 144A.351, and employ a variety of methods to improve the state's
70.17 capacity to meet the informed decisions of those people who want to move out of corporate
70.18 foster care or community residential settings, long-term ~~care~~ service needs within budgetary
70.19 limits, including seeking proposals from service providers or lead agencies to change service
70.20 type, capacity, or location to improve services, increase the independence of residents, and
70.21 better meet needs identified by the long-term ~~care~~ services and supports reports and statewide
70.22 data and information. By February 1, 2013, and August 1, 2014, and each following year,
70.23 the commissioner shall provide information and data and targets on ~~the overall~~ capacity of
70.24 licensed long-term ~~care~~ services and supports, actions taken under this subdivision to manage
70.25 statewide long-term ~~care~~ services and supports resources, and any recommendations for
70.26 change to the legislative committees with jurisdiction over health and human services budget.

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

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

71.7 (h) The commissioner may adjust capacity to address needs identified in section
71.8 144A.351. Under this authority, the commissioner may approve new licensed settings or
71.9 delicense exiting settings. Delicensing of settings will be accomplished through a process
71.10 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
71.11 information and data on capacity of licensed long-term services and supports, actions taken
71.12 under the subdivision to manage statewide long-term services and supports resources, and
71.13 any recommendations for change to the legislative committees with jurisdiction over the
71.14 health and human services budget.

71.15 (i) The commissioner must notify a license holder when its corporate foster care or
71.16 community residential setting licensed beds are reduced under this section. The notice of
71.17 reduction of licensed beds must be in writing and delivered to the license holder by certified
71.18 mail or personal service. The notice must state why the licensed beds are reduced and must
71.19 inform the license holder of its right to request reconsideration by the commissioner. The
71.20 license holder's request for reconsideration must be in writing. If mailed, the request for
71.21 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
71.22 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
71.23 reconsideration is made by personal service, it must be received by the commissioner within
71.24 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

71.25 (j) The commissioner shall not issue an initial license for children's residential treatment
71.26 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
71.27 for a program that Centers for Medicare and Medicaid Services would consider an institution
71.28 for mental diseases.

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

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

71.34 (b) The license holder shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

- 73.1 (3) the name, address, and telephone number of the local agency to which a resident or
73.2 a resident's legal representative may submit an oral or written complaint.
- 73.3 (b) Adult foster care resident rights include the right to:
- 73.4 (1) have daily, private access to and use of a non-coin-operated telephone for local and
73.5 long-distance telephone calls made collect or paid for by the resident;
- 73.6 (2) receive and send, without interference, uncensored, unopened mail or electronic
73.7 correspondence or communication;
- 73.8 (3) have use of and free access to common areas in the residence and the freedom to
73.9 come and go from the residence at will;
- 73.10 (4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious
73.11 adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy
73.12 in the resident's bedroom;
- 73.13 (5) keep, use, and access the resident's personal clothing and possessions as space permits,
73.14 unless this right infringes on the health, safety, or rights of another resident or household
73.15 member, including the right to access the resident's personal possessions at any time;
- 73.16 (6) choose the resident's visitors and time of visits and participate in activities of
73.17 commercial, religious, political, and community groups without interference if the activities
73.18 do not infringe on the rights of another resident or household member;
- 73.19 (7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents
73.20 of the adult foster home, the residents have the right to share a bedroom and bed;
- 73.21 (8) privacy, including use of the lock on the resident's bedroom door or unit door. A
73.22 resident's privacy must be respected by license holders, caregivers, household members,
73.23 and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking
73.24 consent before entering, except in an emergency;
- 73.25 (9) furnish and decorate the resident's bedroom or living unit;
- 73.26 (10) engage in chosen activities and have an individual schedule supported by the license
73.27 holder that meets the resident's preferences;
- 73.28 (11) freedom and support to access food at any time;
- 73.29 (12) have personal, financial, service, health, and medical information kept private, and
73.30 be advised of disclosure of this information by the license holder;

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

74.3 (14) be free from maltreatment;

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

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

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

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

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

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

74.15 (c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8),
 74.16 (10), and (11), is allowed only if determined necessary to ensure the health, safety, and
 74.17 well-being of the resident. Any restriction of a resident's right must be documented and
 74.18 justified in the resident's individual abuse prevention plan required by sections 245A.65,
 74.19 subdivision 2, paragraph (b) and 626.557, subdivision 14. For a resident served under section
 74.20 256B.0915, the case manager must be part of the interdisciplinary team under section
 74.21 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least
 74.22 restrictive manner necessary to protect the resident and provide support to reduce or eliminate
 74.23 the need for the restriction.

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

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

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

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

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

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

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

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

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

75.11 (5) the program ceases to operate; or

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

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

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

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

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

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

75.27 (1) the reason for the action;

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

76.1 (3) the resident's right to appeal the service termination under section 256.045, subdivision
 76.2 3, paragraph (a); and

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

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

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

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

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

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

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

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

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

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

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

76.22 (3) be free from maltreatment;

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

76.25 (i) emergency use of manual restraint to protect the person from imminent danger to self
 76.26 or others according to the requirements in section 245D.061 or successor provisions; or (ii)
 76.27 the use of safety interventions as part of a positive support transition plan under section
 76.28 245D.06, subdivision 8, or successor provisions;

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

- 77.1 (6) be treated with courtesy and respect and receive respectful treatment of the person's
77.2 property;
- 77.3 (7) reasonable observance of cultural and ethnic practice and religion;
- 77.4 (8) be free from bias and harassment regarding race, gender, age, disability, spirituality,
77.5 and sexual orientation;
- 77.6 (9) be informed of and use the license holder's grievance policy and procedures, including
77.7 knowing how to contact persons responsible for addressing problems and to appeal under
77.8 section 256.045;
- 77.9 (10) know the name, telephone number, and the Web site, e-mail, and street addresses
77.10 of protection and advocacy services, including the appropriate state-appointed ombudsman,
77.11 and a brief description of how to file a complaint with these offices;
- 77.12 (11) assert these rights personally, or have them asserted by the person's family,
77.13 authorized representative, or legal representative, without retaliation;
- 77.14 (12) give or withhold written informed consent to participate in any research or
77.15 experimental treatment;
- 77.16 (13) associate with other persons of the person's choice;
- 77.17 (14) personal privacy, including the right to use the lock on the person's bedroom or unit
77.18 door; and
- 77.19 (15) engage in chosen activities; and
- 77.20 (16) access to the person's personal possessions at any time, including financial resources.
- 77.21 (b) For a person residing in a residential site licensed according to chapter 245A, or
77.22 where the license holder is the owner, lessor, or tenant of the residential service site,
77.23 protection-related rights also include the right to:
- 77.24 (1) have daily, private access to and use of a non-coin-operated telephone for local calls
77.25 and long-distance calls made collect or paid for by the person;
- 77.26 (2) receive and send, without interference, uncensored, unopened mail or electronic
77.27 correspondence or communication;
- 77.28 (3) have use of and free access to common areas in the residence and the freedom to
77.29 come and go from the residence at will; and

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

78.4 (5) the freedom and support to access food at any time;

78.5 (6) the freedom to furnish and decorate the person's bedroom or living unit;

78.6 (7) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling
 78.7 paint, mold, vermin, and insects;

78.8 (8) a setting that is free from hazards that threaten the person's health or safety;

78.9 (9) a setting that meets state and local building and zoning definitions of a dwelling unit
 78.10 in a residential occupancy; and

78.11 (10) have access to potable water and three nutritionally balanced meals and nutritious
 78.12 snacks between meals each day.

78.13 (c) Restriction of a person's rights under paragraph (a), clauses (13) to ~~(15)~~ (16), or
 78.14 paragraph (b) is allowed only if determined necessary to ensure the health, safety, and
 78.15 well-being of the person. Any restriction of those rights must be documented in the person's
 78.16 coordinated service and support plan or coordinated service and support plan addendum.
 78.17 The restriction must be implemented in the least restrictive alternative manner necessary
 78.18 to protect the person and provide support to reduce or eliminate the need for the restriction
 78.19 in the most integrated setting and inclusive manner. The documentation must include the
 78.20 following information:

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

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

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

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

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

79.1 Sec. 9. Minnesota Statutes 2016, section 245D.071, subdivision 3, is amended to read:

79.2 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation
79.3 the license holder must complete a preliminary coordinated service and support plan
79.4 addendum based on the coordinated service and support plan.

79.5 (b) Within the scope of services, the license holder must, at a minimum, complete
79.6 assessments in the following areas before the 45-day planning meeting:

79.7 (1) the person's ability to self-manage health and medical needs to maintain or improve
79.8 physical, mental, and emotional well-being, including, when applicable, allergies, seizures,
79.9 choking, special dietary needs, chronic medical conditions, self-administration of medication
79.10 or treatment orders, preventative screening, and medical and dental appointments;

79.11 (2) the person's ability to self-manage personal safety to avoid injury or accident in the
79.12 service setting, including, when applicable, risk of falling, mobility, regulating water
79.13 temperature, community survival skills, water safety skills, and sensory disabilities; and

79.14 (3) the person's ability to self-manage symptoms or behavior that may otherwise result
79.15 in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension
79.16 or termination of services by the license holder, or other symptoms or behaviors that may
79.17 jeopardize the health and welfare of the person or others.

79.18 Assessments must produce information about the person that describes the person's overall
79.19 strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be
79.20 based on the person's status within the last 12 months at the time of service initiation.

79.21 Assessments based on older information must be documented and justified. Assessments
79.22 must be conducted annually at a minimum or within 30 days of a written request from the
79.23 person or the person's legal representative or case manager. The results must be reviewed
79.24 by the support team or expanded support team as part of a service plan review.

79.25 (c) Within 45 days of service initiation, the license holder must meet with the person,
79.26 the person's legal representative, the case manager, and other members of the support team
79.27 or expanded support team to determine the following based on information obtained from
79.28 the assessments identified in paragraph (b), the person's identified needs in the coordinated
79.29 service and support plan, and the requirements in subdivision 4 and section 245D.07,
79.30 subdivision 1a:

79.31 (1) the scope of the services to be provided to support the person's daily needs and
79.32 activities;

80.1 (2) the person's desired outcomes and the supports necessary to accomplish the person's
80.2 desired outcomes;

80.3 (3) the person's preferences for how services and supports are provided, including how
80.4 the provider will support the person to have control of the person's schedule;

80.5 (4) whether the current service setting is the most integrated setting available and
80.6 appropriate for the person; and

80.7 (5) how services must be coordinated across other providers licensed under this chapter
80.8 serving the person and members of the support team or expanded support team to ensure
80.9 continuity of care and coordination of services for the person.

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

80.11 Sec. 10. Minnesota Statutes 2016, section 245D.11, subdivision 4, is amended to read:

80.12 Subd. 4. **Admission criteria.** The license holder must establish policies and procedures
80.13 that promote continuity of care by ensuring that admission or service initiation criteria:

80.14 (1) is consistent with the service-related rights identified in section 245D.04, subdivisions
80.15 2, clauses (4) to (7), and 3, clause (8);

80.16 (2) identifies the criteria to be applied in determining whether the license holder can
80.17 develop services to meet the needs specified in the person's coordinated service and support
80.18 plan;

80.19 (3) requires a license holder providing services in a health care facility to comply with
80.20 the requirements in section 243.166, subdivision 4b, to provide notification to residents
80.21 when a registered predatory offender is admitted into the program or to a potential admission
80.22 when the facility was already serving a registered predatory offender. For purposes of this
80.23 clause, "health care facility" means a facility licensed by the commissioner as a residential
80.24 facility under chapter 245A to provide adult foster care or residential services to persons
80.25 with disabilities; ~~and~~

80.26 (4) requires that when a person or the person's legal representative requests services
80.27 from the license holder, a refusal to admit the person must be based on an evaluation of the
80.28 person's assessed needs and the license holder's lack of capacity to meet the needs of the
80.29 person. The license holder must not refuse to admit a person based solely on the type of
80.30 residential services the person is receiving, or solely on the person's severity of disability,
80.31 orthopedic or neurological handicaps, sight or hearing impairments, lack of communication
80.32 skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress.

81.1 Documentation of the basis for refusal must be provided to the person or the person's legal
81.2 representative and case manager upon request; and

81.3 (5) requires the person or the person's legal representative and license holder to sign and
81.4 date the residency agreement when the license holder provides foster care or supported
81.5 living services under section 245D.03, subdivision 1, paragraph (c), clause (3), item (i) or
81.6 (ii), to a person living in a community residential setting defined in section 245D.02,
81.7 subdivision 4a; an adult foster home defined in Minnesota Rules, part 9555.5105, subpart
81.8 5; or a foster family home defined in Minnesota Rules, part 9560.0521, subpart 12. The
81.9 residency agreement must include service termination requirements specified in section
81.10 245D.10, subdivision 3a, paragraphs (b) to (f). The residency agreement must be reviewed
81.11 annually, dated, and signed by the person or the person's legal representative and license
81.12 holder.

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

81.14 Sec. 11. Minnesota Statutes 2016, section 245D.24, subdivision 3, is amended to read:

81.15 Subd. 3. **Bedrooms.** (a) ~~People~~ Each person receiving services must have a choice of
81.16 roommate and must mutually consent, in writing, to sharing a bedroom with one another.
81.17 No more than two people receiving services may share one bedroom.

81.18 (b) A single occupancy bedroom must have at least 80 square feet of floor space with a
81.19 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
81.20 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and other
81.21 habitable rooms by floor-to-ceiling walls containing no openings except doorways and must
81.22 not serve as a corridor to another room used in daily living.

81.23 (c) A person's personal possessions and items for the person's own use are the only items
81.24 permitted to be stored in a person's bedroom.

81.25 (d) Unless otherwise documented through assessment as a safety concern for the person,
81.26 each person must be provided with the following furnishings:

81.27 (1) a separate bed of proper size and height for the convenience and comfort of the
81.28 person, with a clean mattress in good repair;

81.29 (2) clean bedding appropriate for the season for each person;

81.30 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
81.31 possessions and clothing; and

81.32 (4) a mirror for grooming.

82.1 (e) When possible, a person must be allowed to have items of furniture that the person
82.2 personally owns in the bedroom, unless doing so would interfere with safety precautions,
82.3 violate a building or fire code, or interfere with another person's use of the bedroom. A
82.4 person may choose not to have a cabinet, dresser, shelves, or a mirror in the bedroom, as
82.5 otherwise required under paragraph (d), clause (3) or (4). A person may choose to use a
82.6 mattress other than an innerspring mattress and may choose not to have the mattress on a
82.7 mattress frame or support. If a person chooses not to have a piece of required furniture, the
82.8 license holder must document this choice and is not required to provide the item. If a person
82.9 chooses to use a mattress other than an innerspring mattress or chooses not to have a mattress
82.10 frame or support, the license holder must document this choice and allow the alternative
82.11 desired by the person.

82.12 (f) A person must be allowed to bring personal possessions into the bedroom and other
82.13 designated storage space, if such space is available, in the residence. The person must be
82.14 allowed to accumulate possessions to the extent the residence is able to accommodate them,
82.15 unless doing so is contraindicated for the person's physical or mental health, would interfere
82.16 with safety precautions or another person's use of the bedroom, or would violate a building
82.17 or fire code. The license holder must allow for locked storage of personal items. Any
82.18 restriction on the possession or locked storage of personal items, including requiring a
82.19 person to use a lock provided by the license holder, must comply with section 245D.04,
82.20 subdivision 3, paragraph (c), and allow the person to be present if and when the license
82.21 holder opens the lock.

82.22 (g) A person must be allowed to lock the person's bedroom door. The license holder
82.23 must document and assess the physical plant and the environment, and the population served,
82.24 and identify the risk factors that require using locked doors, and the specific action taken
82.25 to minimize the safety risk to a person receiving services at the site.

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

82.27 Sec. 12. Minnesota Statutes 2016, section 256.045, subdivision 3, is amended to read:

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

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

83.1 (2) any patient or relative aggrieved by an order of the commissioner under section
83.2 252.27;

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

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

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

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

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

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

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

83.19 (10) except as provided under chapter 245C, an individual disqualified under sections
83.20 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23,
83.21 on the basis of serious or recurring maltreatment; a preponderance of the evidence that the
83.22 individual has committed an act or acts that meet the definition of any of the crimes listed
83.23 in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section
83.24 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment
83.25 determination under clause (4) or (9) and a disqualification under this clause in which the
83.26 basis for a disqualification is serious or recurring maltreatment, shall be consolidated into
83.27 a single fair hearing. In such cases, the scope of review by the human services judge shall
83.28 include both the maltreatment determination and the disqualification. The failure to exercise
83.29 the right to an administrative reconsideration shall not be a bar to a hearing under this section
83.30 if federal law provides an individual the right to a hearing to dispute a finding of
83.31 maltreatment;

83.32 (11) any person with an outstanding debt resulting from receipt of public assistance,
83.33 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the

84.1 Department of Human Services or a county agency. The scope of the appeal is the validity
 84.2 of the claimant agency's intention to request a setoff of a refund under chapter 270A against
 84.3 the debt;

84.4 (12) a person issued a notice of service termination under section 245D.10, subdivision
 84.5 3a, from residential supports and services as defined in section 245D.03, subdivision 1,
 84.6 paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; ~~or~~

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

84.9 (14) a person issued a notice of service termination under section 245A.11, subdivision
 84.10 11, that is not otherwise subject to appeal under subdivision 4a.

84.11 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10),
 84.12 is the only administrative appeal to the final agency determination specifically, including
 84.13 a challenge to the accuracy and completeness of data under section 13.04. Hearings requested
 84.14 under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or
 84.15 after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged
 84.16 to have maltreated a resident prior to October 1, 1995, shall be held as a contested case
 84.17 proceeding under the provisions of chapter 14. Hearings requested under paragraph (a),
 84.18 clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A
 84.19 hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only
 84.20 available when there is no district court action pending. If such action is filed in district
 84.21 court while an administrative review is pending that arises out of some or all of the events
 84.22 or circumstances on which the appeal is based, the administrative review must be suspended
 84.23 until the judicial actions are completed. If the district court proceedings are completed,
 84.24 dismissed, or overturned, the matter may be considered in an administrative hearing.

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

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

84.32 (e) The scope of hearings under paragraph (a), ~~clause~~ clauses (12) and (14), shall be
 84.33 limited to whether the proposed termination of services is authorized under section 245D.10,
 84.34 subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements

85.1 of section 245D.10, subdivision 3a, ~~paragraph~~ paragraphs (c) to (e), or 245A.11, subdivision
 85.2 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of
 85.3 termination of services, the scope of the hearing shall also include whether the case
 85.4 management provider has finalized arrangements for a residential facility, a program, or
 85.5 services that will meet the assessed needs of the recipient by the effective date of the service
 85.6 termination.

85.7 (f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor
 85.8 under contract with a county agency to provide social services is not a party and may not
 85.9 request a hearing under this section, except if assisting a recipient as provided in subdivision
 85.10 4.

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

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

85.17 (i) Unless federal or Minnesota law specifies a different time frame in which to file an
 85.18 appeal, an individual or organization specified in this section may contest the specified
 85.19 action, decision, or final disposition before the state agency by submitting a written request
 85.20 for a hearing to the state agency within 30 days after receiving written notice of the action,
 85.21 decision, or final disposition, or within 90 days of such written notice if the applicant,
 85.22 recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision
 85.23 13, why the request was not submitted within the 30-day time limit. The individual filing
 85.24 the appeal has the burden of proving good cause by a preponderance of the evidence.

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

85.26 Sec. 13. **[256B.051] HOUSING SUPPORT SERVICES.**

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

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

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

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

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

86.9 (e) "Individual with a disability" means:

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

86.13 (2) an individual who meets a category of eligibility under section 256D.05, subdivision
86.14 1, paragraph (a), clauses (1), (3), (5) to (9), or (14).

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

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

86.19 (1) is 18 years of age or older;

86.20 (2) is enrolled in medical assistance;

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

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

86.25 (5) has housing instability evidenced by:

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

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

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

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

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

87.5 (1) an assessor according to the criteria established in section 256B.0911, subdivision
87.6 3a, using a format established by the commissioner;

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

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

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

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

87.16 (b) Housing transition services are defined as:

87.17 (1) tenant screening and housing assessment;

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

87.19 (3) identifying resources to cover onetime moving expenses;

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

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

87.22 (6) developing a housing support crisis plan.

87.23 (c) Housing and tenancy sustaining services include:

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

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

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

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

88.3 (5) assistance with housing recertification process;

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

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

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

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

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

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

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

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

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

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

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

89.1 Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

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

89.11 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
89.12 assessors to conduct the assessment. For a person with complex health care needs, a public
89.13 health or registered nurse from the team must be consulted.

89.14 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
89.15 be used to complete a comprehensive, person-centered assessment. The assessment must
89.16 include the health, psychological, functional, environmental, and social needs of the
89.17 individual necessary to develop a community support plan that meets the individual's needs
89.18 and preferences.

89.19 (d) The assessment must be conducted in a face-to-face interview with the person being
89.20 assessed and the person's legal representative. At the request of the person, other individuals
89.21 may participate in the assessment to provide information on the needs, strengths, and
89.22 preferences of the person necessary to develop a community support plan that ensures the
89.23 person's health and safety. Except for legal representatives or family members invited by
89.24 the person, persons participating in the assessment may not be a provider of service or have
89.25 any financial interest in the provision of services. For persons who are to be assessed for
89.26 elderly waiver customized living services under section 256B.0915, with the permission of
89.27 the person being assessed or the person's designated or legal representative, the client's
89.28 current or proposed provider of services may submit a copy of the provider's nursing
89.29 assessment or written report outlining its recommendations regarding the client's care needs.
89.30 The person conducting the assessment must notify the provider of the date by which this
89.31 information is to be submitted. This information shall be provided to the person conducting
89.32 the assessment prior to the assessment. For a person who is to be assessed for waiver services
89.33 under section 256B.092 or 256B.49, with the permission of the person being assessed or
89.34 the person's designated legal representative, the person's current provider of services may
89.35 submit a written report outlining recommendations regarding the person's care needs prepared

90.1 by a direct service employee with at least 20 hours of service to that client. The person
90.2 conducting the assessment or reassessment must notify the provider of the date by which
90.3 this information is to be submitted. This information shall be provided to the person
90.4 conducting the assessment and the person or the person's legal representative, and must be
90.5 considered prior to the finalization of the assessment or reassessment.

90.6 (e) The person or the person's legal representative must be provided with a written
90.7 community support plan within 40 calendar days of the assessment visit, regardless of
90.8 whether the individual is eligible for Minnesota health care programs. The written community
90.9 support plan must include:

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

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

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

90.15 (4) referral information; and

90.16 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

91.13 (4) the role of long-term care consultation assessment and support planning in eligibility
91.14 determination for waiver and alternative care programs, and state plan home care, case
91.15 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
91.16 and (b);

91.17 (5) information about Minnesota health care programs;

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

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

91.21 (8) the certified assessor's decision regarding the person's need for institutional level of
91.22 care as determined under criteria established in subdivision 4e and the certified assessor's
91.23 decision regarding eligibility for all services and programs as defined in subdivision 1a,
91.24 paragraphs (a), clause (6), and (b); and

91.25 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
91.26 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
91.27 (8), and (b), and incorporating the decision regarding the need for institutional level of care
91.28 or the lead agency's final decisions regarding public programs eligibility according to section
91.29 256.045, subdivision 3.

91.30 (i) Face-to-face assessment completed as part of eligibility determination for the
91.31 alternative care, elderly waiver, community access for disability inclusion, community
91.32 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,

92.1 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
92.2 the date of assessment.

92.3 (j) The effective eligibility start date for programs in paragraph (i) can never be prior to
92.4 the date of assessment. If an assessment was completed more than 60 days before the
92.5 effective waiver or alternative care program eligibility start date, assessment and support
92.6 plan information must be updated and documented in the department's Medicaid Management
92.7 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
92.8 state plan services, the effective date of eligibility for programs included in paragraph (i)
92.9 cannot be prior to the date the most recent updated assessment is completed.

92.10 (k) At the time of reassessment, the certified assessor shall assess each person receiving
92.11 waiver services currently residing in a community residential setting, or licensed adult foster
92.12 care home that is not the primary residence of the license holder, or in which the license
92.13 holder is not the primary caregiver, to determine if that person would prefer to be served in
92.14 a community-living settings as defined in section 256B.49, subdivision 23. The certified
92.15 assessor shall offer the person, through a person-centered planning process, the option to
92.16 receive alternative housing and service options.

92.17 Sec. 15. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

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

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

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

93.1 Sec. 16. Minnesota Statutes 2016, section 256B.092, subdivision 4, is amended to read:

93.2 Subd. 4. **Home and community-based services for developmental disabilities.** (a)

93.3 The commissioner shall make payments to approved vendors participating in the medical
93.4 assistance program to pay costs of providing home and community-based services, including
93.5 case management service activities provided as an approved home and community-based
93.6 service, to medical assistance eligible persons with developmental disabilities who have
93.7 been screened under subdivision 7 and according to federal requirements. Federal
93.8 requirements include those services and limitations included in the federally approved
93.9 application for home and community-based services for persons with developmental
93.10 disabilities and subsequent amendments.

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

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

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

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

94.1 Sec. 17. Minnesota Statutes 2016, section 256B.49, subdivision 11, is amended to read:

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

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

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

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

94.10 (4) obtain federal financial participation.

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

94.17 (c) The commissioner shall provide interested persons serving on agency advisory
94.18 committees, task forces, the Centers for Independent Living, and others who request to be
94.19 on a list to receive, notice of, and an opportunity to comment on, at least 30 days before
94.20 any effective dates, (1) any substantive changes to the state's disability services program
94.21 manual, or (2) changes or amendments to the federally approved applications for home and
94.22 community-based waivers, prior to their submission to the federal Centers for Medicare
94.23 and Medicaid Services.

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

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

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

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

95.2 Sec. 18. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

95.3 Subd. 15. **Coordinated service and support plan; comprehensive transitional service**
95.4 **plan; maintenance service plan.** (a) Each recipient of home and community-based waived
95.5 services shall be provided a copy of the written coordinated service and support plan which
95.6 meets the requirements in section 256B.092, subdivision 1b.

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

95.16 Within ten days following an assessment, a comprehensive transitional service plan must
95.17 be developed incorporating elements of a comprehensive functional assessment and including
95.18 short-term measurable outcomes and timelines for achievement of and reporting on these
95.19 outcomes. Functional milestones must also be identified and reported according to the
95.20 timelines agreed upon by the transitional service planning team. In addition, the
95.21 comprehensive transitional service plan must identify additional supports that may assist
95.22 in the achievement of the fundamental service outcome such as the development of greater
95.23 natural community support, increased collaboration among agencies, and technological
95.24 supports.

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

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

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

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

96.14 (e) When a county is evaluating denials, reductions, or terminations of home and
96.15 community-based services under this section for an individual, the case manager shall offer
96.16 to meet with the individual or the individual's guardian in order to discuss the prioritization
96.17 of service needs within the coordinated service and support plan, comprehensive transitional
96.18 service plan, or maintenance service plan. The reduction in the authorized services for an
96.19 individual due to changes in funding for waived services may not exceed the amount
96.20 needed to ensure medically necessary services to meet the individual's health, safety, and
96.21 welfare.

96.22 ~~(f) At the time of reassessment, local agency case managers shall assess each recipient~~
96.23 ~~of community access for disability inclusion or brain injury waived services currently~~
96.24 ~~residing in a licensed adult foster home that is not the primary residence of the license~~
96.25 ~~holder, or in which the license holder is not the primary caregiver, to determine if that~~
96.26 ~~recipient could appropriately be served in a community living setting. If appropriate for the~~
96.27 ~~recipient, the case manager shall offer the recipient, through a person-centered planning~~
96.28 ~~process, the option to receive alternative housing and service options. In the event that the~~
96.29 ~~recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled~~
96.30 ~~with another recipient of waiver services and group residential housing and the licensed~~
96.31 ~~capacity shall be reduced accordingly, unless the savings required by the licensed bed closure~~
96.32 ~~reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40,~~
96.33 ~~paragraph (f), for foster care settings where the physical location is not the primary residence~~
96.34 ~~of the license holder are met through voluntary changes described in section 245A.03,~~
96.35 ~~subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the~~

97.1 ~~adult foster home becomes no longer viable due to these transfers, the county agency, with~~
 97.2 ~~the assistance of the department, shall facilitate a consolidation of settings or closure. This~~
 97.3 ~~reassessment process shall be completed by July 1, 2013.~~

97.4 Sec. 19. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

97.5 Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following
 97.6 adjustments to the rate generated by the framework to assure budget neutrality until the rate
 97.7 information is available to implement paragraph (b). The rate generated by the framework
 97.8 shall be multiplied by the appropriate factor, as designated below:

97.9 (1) for residential services: 1.003;

97.10 (2) for day services: 1.000;

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

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

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

97.26 (c) A service rate developed using values in subdivision 5, paragraph (a), clause (11),
 97.27 is not subject to budget neutrality adjustments.

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

97.29 Sec. 20. Minnesota Statutes 2016, section 256B.493, subdivision 1, is amended to read:

97.30 Subdivision 1. **Commissioner's duties; report.** The commissioner of human services
 97.31 ~~shall solicit proposals for the conversion of services provided for persons with disabilities~~

98.1 ~~in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, or community~~
 98.2 ~~residential settings licensed under chapter 245D, to other types of community settings in~~
 98.3 ~~conjunction with the closure of identified licensed adult foster care settings~~ has the authority
 98.4 to manage statewide licensed corporate foster care or community residential settings capacity,
 98.5 including the reduction and realignment of licensed capacity of a current foster care or
 98.6 community residential settings to accomplish the consolidation or closure of settings. The
 98.7 commissioner shall implement a program for planned closure of licensed corporate adult
 98.8 foster care or community residential settings, necessary as a preferred method to: (1) respond
 98.9 to the informed decisions of those individuals who want to move out of these settings into
 98.10 other types of community settings; and (2) achieve necessary budgetary savings required
 98.11 in section 245A.03, subdivision 7, paragraphs (c) and (d).

98.12 Sec. 21. Minnesota Statutes 2016, section 256B.493, subdivision 2, is amended to read:

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

98.22 Sec. 22. Minnesota Statutes 2016, section 256B.493, is amended by adding a subdivision
 98.23 to read:

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

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

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

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

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

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

99.11 (1) target counties and geographic areas which have:

99.12 (i) need for other types of services;

99.13 (ii) need for specialized services;

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

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

99.17 (2) demonstrate savings of medical assistance expenditures; and

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

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

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

99.26 Sec. 23. Minnesota Statutes 2016, section 256D.44, subdivision 4, is amended to read:

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

100.1 (1) a physician certifies that the absence is not expected to continue for more than three
100.2 months;

100.3 (2) a physician certifies that the recipient will be able to return to independent living;
100.4 and

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

100.6 Sec. 24. Minnesota Statutes 2016, section 256D.44, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

101.2 ~~(b)~~ (c) Payment for nonrecurring special needs must be allowed for necessary home
101.3 repairs or necessary repairs or replacement of household furniture and appliances using the
101.4 payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as
101.5 long as other funding sources are not available.

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

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

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

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

101.27 (i) relocating from an institution, a setting authorized to receive housing support under
101.28 chapter 256I, or an adult mental health residential treatment program under section
101.29 256B.0622; or

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

101.31 (iii) home and community-based waiver recipients living in their own home or rented
101.32 or leased apartment ~~which is not owned, operated, or controlled by a provider of service~~
101.33 ~~not related by blood or marriage, unless allowed under paragraph (g).~~

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

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

102.13 ~~(g) Notwithstanding this subdivision, to access housing and services as provided in~~
 102.14 ~~paragraph (f), the recipient may choose housing that may be owned, operated, or controlled~~
 102.15 ~~by the recipient's service provider. When housing is controlled by the service provider, the~~
 102.16 ~~individual may choose the individual's own service provider as provided in section 256B.49,~~
 102.17 ~~subdivision 23, clause (3). When the housing is controlled by the service provider, the~~
 102.18 ~~service provider shall implement a plan with the recipient to transition the lease to the~~
 102.19 ~~recipient's name. Within two years of signing the initial lease, the service provider shall~~
 102.20 ~~transfer the lease entered into under this subdivision to the recipient. In the event the landlord~~
 102.21 ~~denies this transfer, the commissioner may approve an exception within sufficient time to~~
 102.22 ~~ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.~~

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

102.26 Sec. 25. Minnesota Statutes 2016, section 256I.03, subdivision 8, is amended to read:

102.27 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
 102.28 services provided to residents of group residential housing providers individuals in addition
 102.29 to room and board including, but not limited to, oversight and up to 24-hour supervision,
 102.30 medication reminders, assistance with transportation, arranging for meetings and
 102.31 appointments, and arranging for medical and social services.

103.1 Sec. 26. Minnesota Statutes 2016, section 256I.04, subdivision 1, is amended to read:

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

103.7 (a) The individual is aged, blind, or is over 18 years of age and disabled as determined
103.8 under the criteria used by the title II program of the Social Security Act, and meets the
103.9 resource restrictions and standards of section 256P.02, and the individual's countable income
103.10 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
103.11 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
103.12 income actually made available to a community spouse by an elderly waiver participant
103.13 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,
103.14 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
103.15 provider of ~~group residential~~ housing support in which the individual resides.

103.16 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
103.17 paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and the
103.18 individual's resources are less than the standards specified by section 256P.02, and the
103.19 individual's countable income as determined under section 256P.06, less the medical
103.20 assistance personal needs allowance under section 256B.35 is less than the monthly rate
103.21 specified in the agency's agreement with the provider of ~~group residential~~ housing support
103.22 in which the individual resides.

103.23 (c) The individual receives licensed residential crisis stabilization services under section
103.24 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive
103.25 concurrent group residential housing payments if receiving licensed residential crisis
103.26 stabilization services under section 256B.0624, subdivision 7.

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

103.28 Sec. 27. Minnesota Statutes 2016, section 256I.04, subdivision 2d, is amended to read:

103.29 Subd. 2d. **Conditions of payment; commissioner's right to suspend or terminate**
103.30 **agreement.** (a) ~~Group residential Housing or supplementary services support~~ support must be
103.31 provided to the satisfaction of the commissioner, as determined at the sole discretion of the
103.32 commissioner's authorized representative, and in accordance with all applicable federal,
103.33 state, and local laws, ordinances, rules, and regulations, including business registration

104.1 requirements of the Office of the Secretary of State. A provider shall not receive payment
104.2 for room and board or supplementary services ~~or housing~~ found by the commissioner to be
104.3 performed or provided in violation of federal, state, or local law, ordinance, rule, or
104.4 regulation.

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

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

104.16 Sec. 28. Minnesota Statutes 2016, section 256I.04, subdivision 2g, is amended to read:

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

104.20 Sec. 29. Minnesota Statutes 2016, section 256I.04, subdivision 3, is amended to read:

104.21 Subd. 3. **Moratorium on development of ~~group residential~~ housing support beds.**

104.22 (a) Agencies shall not enter into agreements for new ~~group residential~~ housing support beds
104.23 with total rates in excess of the MSA equivalent rate except:

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

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

105.1 (3) notwithstanding the provisions of subdivision 2a, for up to ~~190~~ 226 supportive
105.2 housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a
105.3 mental illness, a history of substance abuse, or human immunodeficiency virus or acquired
105.4 immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person
105.5 who is living on the street or in a shelter or discharged from a regional treatment center,
105.6 community hospital, or residential treatment program and has no appropriate housing
105.7 available and lacks the resources and support necessary to access appropriate housing. At
105.8 least 70 percent of the supportive housing units must serve homeless adults with mental
105.9 illness, substance abuse problems, or human immunodeficiency virus or acquired
105.10 immunodeficiency syndrome who are about to be or, within the previous six months, has
105.11 been discharged from a regional treatment center, or a state-contracted psychiatric bed in
105.12 a community hospital, or a residential mental health or chemical dependency treatment
105.13 program. If a person meets the requirements of subdivision 1, paragraph (a), and receives
105.14 a federal or state housing subsidy, the ~~group-residential~~ housing support rate for that person
105.15 is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined
105.16 by subtracting the amount of the person's countable income that exceeds the MSA equivalent
105.17 rate from the ~~group-residential~~ housing support supplementary service rate. A resident in a
105.18 demonstration project site who no longer participates in the demonstration program shall
105.19 retain eligibility for a ~~group-residential~~ housing support payment in an amount determined
105.20 under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under
105.21 section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are
105.22 available and the services can be provided through a managed care entity. If federal matching
105.23 funds are not available, then service funding will continue under section 256I.05, subdivision
105.24 1a;

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

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

105.33 (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent
105.34 persons, operated by a ~~group-residential~~ housing support provider that currently operates a
105.35 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

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

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

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

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

106.18 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
106.19 subdivision 3, the county agency may negotiate a payment not to exceed \$426.37 for other
106.20 services necessary to provide room and board ~~provided by the group residence~~ if the residence
106.21 is licensed by or registered by the Department of Health, or licensed by the Department of
106.22 Human Services to provide services in addition to room and board, and if the provider of
106.23 services is not also concurrently receiving funding for services for a recipient under a home
106.24 and community-based waiver under title XIX of the Social Security Act; or funding from
106.25 the medical assistance program under section 256B.0659, for personal care services for
106.26 residents in the setting; or residing in a setting which receives funding under section 245.73.
106.27 If funding is available for other necessary services through a home and community-based
106.28 waiver, or personal care services under section 256B.0659, then the ~~GRH~~ housing support
106.29 rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case
106.30 may the supplementary service rate exceed \$426.37. The registration and licensure
106.31 requirement does not apply to establishments which are exempt from state licensure because
106.32 they are located on Indian reservations and for which the tribe has prescribed health and
106.33 safety requirements. Service payments under this section may be prohibited under rules to
106.34 prevent the supplanting of federal funds with state funds. The commissioner shall pursue

107.1 the feasibility of obtaining the approval of the Secretary of Health and Human Services to
107.2 provide home and community-based waiver services under title XIX of the Social Security
107.3 Act for residents who are not eligible for an existing home and community-based waiver
107.4 due to a primary diagnosis of mental illness or chemical dependency and shall apply for a
107.5 waiver if it is determined to be cost-effective.

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

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

107.18 Sec. 31. Minnesota Statutes 2016, section 256I.05, subdivision 1c, is amended to read:

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

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

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

107.31 (c) The room and board rates will be increased each year when the MSA equivalent rate
107.32 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less

108.1 the amount of the increase in the medical assistance personal needs allowance under section
108.2 256B.35.

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

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

108.15 (f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid
108.16 for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who
108.17 reside in residences that are licensed by the commissioner of health as a boarding care home,
108.18 but are not certified for the purposes of the medical assistance program. However, an increase
108.19 under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical
108.20 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
108.21 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
108.22 9549.0058.

108.23 Sec. 32. Minnesota Statutes 2016, section 256I.05, subdivision 1e, is amended to read:

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

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

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

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

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

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

109.10 (2) operates a 62-bed facility; and

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

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

109.19 Sec. 33. Minnesota Statutes 2016, section 256I.05, subdivision 1j, is amended to read:

109.20 Subd. 1j. **Supplementary rate for certain facilities; Crow Wing County.**

109.21 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county
109.22 agency shall negotiate a supplementary rate in addition to the rate specified in subdivision
109.23 1, not to exceed \$700 per month, including any legislatively authorized inflationary
109.24 adjustments, for a new 65-bed facility in Crow Wing County that will serve chemically
109.25 dependent persons operated by a ~~group residential~~ housing support provider that currently
109.26 operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in
109.27 January of 2006.

109.28 Sec. 34. Minnesota Statutes 2016, section 256I.05, subdivision 1m, is amended to read:

109.29 Subd. 1m. **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.**

109.30 (a) Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
109.31 shall negotiate a supplemental service rate in addition to the rate specified in subdivision
109.32 1, not to exceed \$700 per month or the existing monthly rate, whichever is higher, including

110.1 any legislatively authorized inflationary adjustments, for a ~~group residential~~ housing support
 110.2 provider that operates two ten-bed facilities, one located in Hennepin County and one located
 110.3 in Ramsey County, which provide community support and serve the mental health needs
 110.4 of individuals who have chronically lived unsheltered, providing 24-hour-per-day supervision.

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

110.9 Sec. 35. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
 110.10 to read:

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

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

110.18 (2) operates a 35-bed facility;

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

110.20 (4) provides 24-hour per day supervision;

110.21 (5) provides onsite support with skilled professionals, including a licensed practical
 110.22 nurse, registered nurses, peer specialists, and resident counselors; and

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

110.24 Sec. 36. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
 110.25 to read:

110.26 Subd. 1q. **Supplemental rate; Olmsted County.** Notwithstanding the provisions of
 110.27 subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a
 110.28 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$750 per
 110.29 month, including any legislatively authorized inflationary adjustments, for a housing support
 110.30 provider located in Olmsted County that operates long-term residential facilities with a total

111.1 of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day
111.2 supervision and other support services.

111.3 Sec. 37. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
111.4 to read:

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

111.11 Sec. 38. Minnesota Statutes 2016, section 256I.05, subdivision 8, is amended to read:

111.12 Subd. 8. **State participation.** For a ~~resident of a group residence~~ person who is eligible
111.13 under section 256I.04, subdivision 1, paragraph (b), state participation in the ~~group residential~~
111.14 housing support payment is determined according to section 256D.03, subdivision 2. For
111.15 a ~~resident of a group residence~~ person who is eligible under section 256I.04, subdivision 1,
111.16 paragraph (a), state participation in the ~~group residential~~ housing support rate is determined
111.17 according to section 256D.36.

111.18 Sec. 39. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
111.19 to read:

111.20 Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a
111.21 cost-neutral transfer of funding from the group residential housing fund to county human
111.22 service agencies for emergency shelter beds removed from the group residential housing
111.23 census under a biennial plan submitted by the county and approved by the commissioner.
111.24 The biennial plan is due August 1, beginning August 1, 2017. The plan must describe: (1)
111.25 anticipated and actual outcomes for persons experiencing homelessness in emergency
111.26 shelters; (2) improved efficiencies in administration; (3) requirements for individual
111.27 eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes.
111.28 The commissioner shall review the county plan to monitor implementation and outcomes
111.29 at least biennially, and more frequently if the commissioner deems necessary.

111.30 (b) The funding under paragraph (a) may be used for the provision of room and board
111.31 or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must
111.32 meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding will be allocated

112.1 annually, and the room and board portion of the allocation shall be adjusted according to
 112.2 the percentage change in the group residential housing room and board rate. The room and
 112.3 board portion of the allocation shall be determined at the time of transfer. The commissioner
 112.4 or county may return beds to the group residential housing fund with 180 days' notice,
 112.5 including financial reconciliation.

112.6 Sec. 40. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
 112.7 to read:

112.8 Subd. 12. **Decrease in supplementary service rate.** For every housing support provider
 112.9 with a supplementary service rate of \$300 or higher, the commissioner shall reduce by five
 112.10 percent the difference between the total supplementary service rate in effect on July 1, 2017,
 112.11 and \$300, and shall reduce by ten percent the difference between the total supplementary
 112.12 service rate in effect on July 1, 2019, and \$300.

112.13 Sec. 41. Minnesota Statutes 2016, section 256I.06, subdivision 2, is amended to read:

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

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

112.21 Sec. 42. Minnesota Statutes 2016, section 256I.06, subdivision 8, is amended to read:

112.22 Subd. 8. **Amount of ~~group residential housing support~~ payment.** (a) The amount of
 112.23 ~~a group residential housing room and board~~ payment to be made on behalf of an eligible
 112.24 individual is determined by subtracting the individual's countable income under section
 112.25 256I.04, subdivision 1, for a whole calendar month from the ~~group residential housing~~
 112.26 ~~charge room and board rate~~ for that same month. The ~~group residential housing charge~~
 112.27 support payment is determined by multiplying the ~~group residential housing support~~ rate
 112.28 times the period of time the individual was a resident or temporarily absent under section
 112.29 256I.05, subdivision 1c, paragraph (d).

112.30 (b) For an individual with earned income under paragraph (a), prospective budgeting
 112.31 must be used to determine the amount of the individual's payment for the following six-month
 112.32 period. An increase in income shall not affect an individual's eligibility or payment amount

113.1 until the month following the reporting month. A decrease in income shall be effective the
113.2 first day of the month after the month in which the decrease is reported.

113.3 (c) For an individual who receives licensed residential crisis stabilization services under
113.4 section 256B.0624, subdivision 7, the amount of group residential housing payment is
113.5 determined by multiplying the group residential housing rate times the period of time the
113.6 individual was a resident.

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

113.8 Sec. 43. **[256I.09] COMMUNITY LIVING INFRASTRUCTURE.**

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

113.17 Sec. 44. **REVISOR'S INSTRUCTION.**

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

113.24	<u>Column A</u>	<u>Column B</u>	<u>Column C</u>
113.25 113.26	<u>144A.071, subdivision 4d</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
113.27 113.28	<u>201.061, subdivision 3</u>	<u>group residential housing</u>	<u>setting authorized to provide housing support</u>
113.29 113.30 113.31	<u>244.052, subdivision 4c</u>	<u>group residential housing facility</u>	<u>licensed setting authorized to provide housing support under section 256I.04</u>
113.32 113.33	<u>245.466, subdivision 7</u>	<u>under group residential housing</u>	<u>by housing support under chapter 256I</u>
113.34	<u>245.466, subdivision 7</u>	<u>from group residential housing</u>	<u>from housing support</u>

114.1	<u>245.4661, subdivision 6</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
114.2			
114.3	<u>245C.10, subdivision 11</u>	<u>group residential housing or supplementary services</u>	<u>housing support</u>
114.4			
114.5	<u>256.01, subdivision 18</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
114.6			
114.7	<u>256.017, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
114.8	<u>256.98, subdivision 8</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
114.9			
114.10	<u>256B.49, subdivision 15</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
114.11			
114.12	<u>256B.4914, subdivision 10</u>	<u>group residential housing rate 3 costs</u>	<u>housing support rate 3 costs under chapter 256I</u>
114.13			
114.14	<u>256B.501, subdivision 4b</u>	<u>group residential housing</u>	<u>housing support</u>
114.15	<u>256B.77, subdivision 12</u>	<u>residential services covered under the group residential housing program</u>	<u>housing support services under chapter 256I</u>
114.16			
114.17			
114.18	<u>256D.44, subdivision 2</u>	<u>group residential housing facility</u>	<u>setting authorized to provide housing support</u>
114.19			
114.20	<u>256G.01, subdivision 3</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
114.21			
114.22	<u>256I.01</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
114.23	<u>256I.02</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
114.24	<u>256I.03, subdivision 2</u>	<u>"Group residential housing"</u>	<u>"Room and board"</u>
114.25	<u>256I.03, subdivision 2</u>	<u>Group residential housing</u>	<u>The room and board</u>
114.26	<u>256I.03, subdivision 3</u>	<u>"Group residential housing"</u>	<u>"Housing support"</u>
114.27	<u>256I.03, subdivision 6</u>	<u>group residential housing</u>	<u>room and board</u>
114.28	<u>256I.03, subdivisions 7 and 9</u>	<u>group residential housing</u>	<u>housing support</u>
114.29	<u>256I.04, subdivisions 1a, 1b, 1c, and 2</u>	<u>group residential housing</u>	<u>housing support</u>
114.30			
114.31	<u>256I.04, subdivision 2a</u>	<u>provide group residential housing</u>	<u>provide housing support</u>
114.32			
114.33	<u>256I.04, subdivision 2a</u>	<u>of group residential housing or supplementary services</u>	<u>of housing support</u>
114.34			
114.35	<u>256I.04, subdivision 2a</u>	<u>complete group residential housing</u>	<u>complete housing support</u>
114.36			
114.37	<u>256I.04, subdivision 2b</u>	<u>group residential housing or supplementary services</u>	<u>housing support</u>
114.38			
114.39	<u>256I.04, subdivision 2b</u>	<u>provision of group residential housing</u>	<u>provision of housing support</u>
114.40			
114.41	<u>256I.04, subdivision 2c</u>	<u>group residential housing or supplementary services</u>	<u>housing support</u>
114.42			
114.43	<u>256I.04, subdivision 2e</u>	<u>group residential housing or supplementary services</u>	<u>housing support</u>
114.44			

115.1	<u>256I.04, subdivision 4</u>	<u>group residential housing</u>	<u>room and board rate</u>
115.2		<u>payment for room and board</u>	
115.3	<u>256I.05, subdivision 1</u>	<u>living in group residential</u>	<u>receiving housing support</u>
115.4		<u>housing</u>	
115.5	<u>256I.05, subdivisions 1h, 1k,</u>	<u>group residential housing</u>	<u>housing support</u>
115.6	<u>1l, 7b, and 7c</u>		
115.7	<u>256I.05, subdivision 2</u>	<u>group residential housing</u>	<u>room and board</u>
115.8	<u>256I.05, subdivision 3</u>	<u>group residential housing</u>	<u>room and board</u>
115.9	<u>256I.05, subdivision 6</u>	<u>reside in group residential</u>	<u>receive housing support</u>
115.10		<u>housing</u>	
115.11	<u>256I.06, subdivisions 1, 3, 4,</u>	<u>group residential housing</u>	<u>housing support</u>
115.12	<u>and 6</u>		
115.13	<u>256I.06, subdivision 7</u>	<u>group residential housing</u>	<u>the housing support</u>
115.14	<u>256I.08</u>	<u>group residential housing</u>	<u>housing support</u>
115.15	<u>256P.03, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
115.16	<u>256P.05, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
115.17	<u>256P.07, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
115.18	<u>256P.08, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
115.19	<u>290A.03, subdivision 8</u>	<u>accepts group residential</u>	<u>accepts housing support</u>
115.20		<u>housing</u>	
115.21	<u>290A.03, subdivision 8</u>	<u>the group residential housing</u>	<u>the housing support program</u>
115.22		<u>program</u>	

ARTICLE 3

CONTINUING CARE

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

115.26 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
 115.27 submit to the commissioner of health MDS assessments that conform with the assessment
 115.28 schedule defined by Code of Federal Regulations, title 42, section 483.20, and published
 115.29 by the United States Department of Health and Human Services, Centers for Medicare and
 115.30 Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version
 115.31 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.
 115.32 The commissioner of health may substitute successor manuals or question and answer
 115.33 documents published by the United States Department of Health and Human Services,
 115.34 Centers for Medicare and Medicaid Services, to replace or supplement the current version
 115.35 of the manual or document.

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

- 116.1 (1) a new admission assessment;
- 116.2 (2) an annual assessment which must have an assessment reference date (ARD) within
116.3 92 days of the previous assessment and the previous comprehensive assessment;
- 116.4 (3) a significant change in status assessment must be completed within 14 days of the
116.5 identification of a significant change, whether improvement or decline, and regardless of
116.6 the amount of time since the last significant change in status assessment;
- 116.7 (4) all quarterly assessments must have an assessment reference date (ARD) within 92
116.8 days of the ARD of the previous assessment;
- 116.9 (5) any significant correction to a prior comprehensive assessment, if the assessment
116.10 being corrected is the current one being used for RUG classification; and
- 116.11 (6) any significant correction to a prior quarterly assessment, if the assessment being
116.12 corrected is the current one being used for RUG classification.
- 116.13 (c) In addition to the assessments listed in paragraph (b), the assessments used to
116.14 determine nursing facility level of care include the following:
- 116.15 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
116.16 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
116.17 Aging; and
- 116.18 (2) a nursing facility level of care determination as provided for under section 256B.0911,
116.19 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
116.20 under section 256B.0911, by a county, tribe, or managed care organization under contract
116.21 with the Department of Human Services.
- 116.22 Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:
- 116.23 **Subd. 6. Penalties for late or nonsubmission.** (a) A facility that fails to complete or
116.24 submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within
116.25 seven days of the time requirements listed in the Long-Term Care Facility Resident
116.26 Assessment Instrument User's Manual is subject to a reduced rate for that resident. The
116.27 reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the
116.28 day of admission for new admission assessments, on the ARD for significant change in
116.29 status assessments, or on the day that the assessment was due for all other assessments and
116.30 continues in effect until the first day of the month following the date of submission and
116.31 acceptance of the resident's assessment.

117.1 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
 117.2 are equal to or greater than ~~1.0~~ 0.1 percent of the total operating costs on the facility's most
 117.3 recent annual statistical and cost report, a facility may apply to the commissioner of human
 117.4 services for a reduction in the total penalty amount. The commissioner of human services,
 117.5 in consultation with the commissioner of health, may, at the sole discretion of the
 117.6 commissioner of human services, limit the penalty for residents covered by medical assistance
 117.7 to ~~15~~ ten days.

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

117.9 Sec. 3. Minnesota Statutes 2016, section 144A.071, subdivision 4d, is amended to read:

117.10 Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in
 117.11 consultation with the commissioner of human services, may approve a request for
 117.12 consolidation of nursing facilities which includes the closure of one or more facilities and
 117.13 the upgrading of the physical plant of the remaining nursing facility or facilities, the costs
 117.14 of which exceed the threshold project limit under subdivision 2, clause (a). The
 117.15 commissioners shall consider the criteria in this section, section 144A.073, and section
 117.16 ~~256B.437~~ 256R.40, in approving or rejecting a consolidation proposal. In the event the
 117.17 commissioners approve the request, the commissioner of human services shall calculate an
 117.18 external fixed costs rate adjustment according to clauses (1) to (3):

117.19 (1) the closure of beds shall not be eligible for a planned closure rate adjustment under
 117.20 section ~~256B.437, subdivision 6~~ 256R.40, subdivision 5;

117.21 (2) the construction project permitted in this clause shall not be eligible for a threshold
 117.22 project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception
 117.23 adjustment under section 144A.073; and

117.24 (3) the payment rate for external fixed costs for a remaining facility or facilities shall
 117.25 be increased by an amount equal to 65 percent of the projected net cost savings to the state
 117.26 calculated in paragraph (b), divided by the state's medical assistance percentage of medical
 117.27 assistance dollars, and then divided by estimated medical assistance resident days, as
 117.28 determined in paragraph (c), of the remaining nursing facility or facilities in the request in
 117.29 this paragraph. The rate adjustment is effective on the ~~later of the first day of the month~~
 117.30 following first day of the month of January or July, whichever date occurs first following
 117.31 both the completion of the construction upgrades in the consolidation plan or the first day
 117.32 of the month following and the complete closure of a facility closure of the facility or
 117.33 facilities designated for closure in the consolidation plan. If more than one facility is receiving

118.1 upgrades in the consolidation plan, each facility's date of construction completion must be
118.2 evaluated separately.

118.3 (b) For purposes of calculating the net cost savings to the state, the commissioner shall
118.4 consider clauses (1) to (7):

118.5 (1) the annual savings from estimated medical assistance payments from the net number
118.6 of beds closed taking into consideration only beds that are in active service on the date of
118.7 the request and that have been in active service for at least three years;

118.8 (2) the estimated annual cost of increased case load of individuals receiving services
118.9 under the elderly waiver;

118.10 (3) the estimated annual cost of elderly waiver recipients receiving support under group
118.11 residential housing;

118.12 (4) the estimated annual cost of increased case load of individuals receiving services
118.13 under the alternative care program;

118.14 (5) the annual loss of license surcharge payments on closed beds;

118.15 (6) the savings from not paying planned closure rate adjustments that the facilities would
118.16 otherwise be eligible for under section ~~256B.437~~ 256R.40; and

118.17 (7) the savings from not paying external fixed costs payment rate adjustments from
118.18 submission of renovation costs that would otherwise be eligible as threshold projects under
118.19 section 256B.434, subdivision 4f.

118.20 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
118.21 assistance resident days of the remaining facility or facilities shall be computed assuming
118.22 95 percent occupancy multiplied by the historical percentage of medical assistance resident
118.23 days of the remaining facility or facilities, as reported on the facility's or facilities' most
118.24 recent nursing facility statistical and cost report filed before the plan of closure is submitted,
118.25 multiplied by 365.

118.26 (d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy
118.27 percentages will be those reported on the facility's or facilities' most recent nursing facility
118.28 statistical and cost report filed before the plan of closure is submitted, and the average
118.29 payment rates shall be calculated based on the approved payment rates in effect at the time
118.30 the consolidation request is submitted.

118.31 (e) To qualify for the external fixed costs payment rate adjustment under this subdivision,
118.32 the closing facilities shall:

119.1 (1) submit an application for closure according to section ~~256B.437, subdivision 3~~
119.2 256R.40, subdivision 2; and

119.3 (2) follow the resident relocation provisions of section 144A.161.

119.4 (f) The county or counties in which a facility or facilities are closed under this subdivision
119.5 shall not be eligible for designation as a hardship area under subdivision 3 for five years
119.6 from the date of the approval of the proposed consolidation. The applicant shall notify the
119.7 county of this limitation and the county shall acknowledge this in a letter of support.

119.8 **EFFECTIVE DATE.** This section is effective for consolidations occurring after July
119.9 1, 2017.

119.10 Sec. 4. Minnesota Statutes 2016, section 256.975, subdivision 7, is amended to read:

119.11 Subd. 7. **Consumer information and assistance and long-term care options**

119.12 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
119.13 statewide service to aid older Minnesotans and their families in making informed choices
119.14 about long-term care options and health care benefits. Language services to persons with
119.15 limited English language skills may be made available. The service, known as Senior
119.16 LinkAge Line, shall serve older adults as the designated Aging and Disability Resource
119.17 Center under United States Code, title 42, section 3001, the Older Americans Act
119.18 Amendments of 2006 in partnership with the Disability Linkage Line under section 256.01,
119.19 subdivision 24, and must be available during business hours through a statewide toll-free
119.20 number and the Internet. The Minnesota Board on Aging shall consult with, and when
119.21 appropriate work through, the area agencies on aging counties, and other entities that serve
119.22 aging and disabled populations of all ages, to provide and maintain the telephone
119.23 infrastructure and related support for the Aging and Disability Resource Center partners
119.24 which agree by memorandum to access the infrastructure, including the designated providers
119.25 of the Senior LinkAge Line and the Disability Linkage Line.

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

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

- 120.1 (2) make the database accessible on the Internet and through other telecommunication
120.2 and media-related tools;
- 120.3 (3) link callers to interactive long-term care screening tools and make these tools available
120.4 through the Internet by integrating the tools with the database;
- 120.5 (4) develop community education materials with a focus on planning for long-term care
120.6 and evaluating independent living, housing, and service options;
- 120.7 (5) conduct an outreach campaign to assist older adults and their caregivers in finding
120.8 information on the Internet and through other means of communication;
- 120.9 (6) implement a messaging system for overflow callers and respond to these callers by
120.10 the next business day;
- 120.11 (7) link callers with county human services and other providers to receive more in-depth
120.12 assistance and consultation related to long-term care options;
- 120.13 (8) link callers with quality profiles for nursing facilities and other home and
120.14 community-based services providers developed by the commissioners of health and human
120.15 services;
- 120.16 (9) develop an outreach plan to seniors and their caregivers with a particular focus on
120.17 establishing a clear presence in places that seniors recognize and:
- 120.18 (i) place a significant emphasis on improved outreach and service to seniors and their
120.19 caregivers by establishing annual plans by neighborhood, city, and county, as necessary, to
120.20 address the unique needs of geographic areas in the state where there are dense populations
120.21 of seniors;
- 120.22 (ii) establish an efficient workforce management approach and assign community living
120.23 specialist staff and volunteers to geographic areas as well as aging and disability resource
120.24 center sites so that seniors and their caregivers and professionals recognize the Senior
120.25 LinkAge Line as the place to call for aging services and information;
- 120.26 (iii) recognize the size and complexity of the metropolitan area service system by working
120.27 with metropolitan counties to establish a clear partnership with them, including seeking
120.28 county advice on the establishment of local aging and disabilities resource center sites; and
- 120.29 (iv) maintain dashboards with metrics that demonstrate how the service is expanding
120.30 and extending or enhancing its outreach efforts in dispersed or hard to reach locations in
120.31 varied population centers;

121.1 (10) incorporate information about the availability of housing options, as well as
121.2 registered housing with services and consumer rights within the MinnesotaHelp.info network
121.3 long-term care database to facilitate consumer comparison of services and costs among
121.4 housing with services establishments and with other in-home services and to support financial
121.5 self-sufficiency as long as possible. Housing with services establishments and their arranged
121.6 home care providers shall provide information that will facilitate price comparisons, including
121.7 delineation of charges for rent and for services available. The commissioners of health and
121.8 human services shall align the data elements required by section 144G.06, the Uniform
121.9 Consumer Information Guide, and this section to provide consumers standardized information
121.10 and ease of comparison of long-term care options. The commissioner of human services
121.11 shall provide the data to the Minnesota Board on Aging for inclusion in the
121.12 MinnesotaHelp.info network long-term care database;

121.13 (11) provide long-term care options counseling. Long-term care options counselors shall:

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

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

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

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

121.29 (12) using risk management and support planning protocols, provide long-term care
121.30 options counseling under clause (13) to current residents of nursing homes deemed
121.31 appropriate for discharge by the commissioner, ~~former residents of nursing homes who~~
121.32 ~~were discharged to community settings, and older adults who request service after~~
121.33 ~~consultation with the Senior LinkAge Line under clause (13).~~ The Senior LinkAge Line
121.34 shall also receive referrals from the residents or staff of nursing homes. who meet a profile

122.1 that demonstrates that the consumer is either at risk of readmission to a nursing home or
 122.2 hospital, or would benefit from long-term care options counseling to age in place. The Senior
 122.3 LinkAge Line shall identify and contact residents or patients deemed appropriate ~~for~~
 122.4 ~~discharge~~ by developing targeting criteria and creating a profile in consultation with the
 122.5 commissioner ~~who~~. The commissioner shall provide designated Senior LinkAge Line contact
 122.6 centers with a list of current or former nursing home residents or people discharged from a
 122.7 hospital or for whom Medicare home care has ended, that meet the criteria as being
 122.8 appropriate for ~~discharge planning~~ long-term care options counseling through a referral via
 122.9 a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a
 122.10 preference to receive long-term care options counseling, with initial assessment and, if
 122.11 appropriate, a referral to:

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

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

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

122.17 (13) develop referral protocols and processes that will assist certified health care homes,
 122.18 Medicare home care, and hospitals to identify at-risk older adults and determine when to
 122.19 refer these individuals to the Senior LinkAge Line for long-term care options counseling
 122.20 under this section. The commissioner is directed to work with the commissioner of health
 122.21 to develop protocols that would comply with the health care home designation criteria and
 122.22 protocols available at the time of hospital discharge or the end of Medicare home care. The
 122.23 commissioner shall keep a record of the number of people who choose long-term care
 122.24 options counseling as a result of this section.

122.25 (c) Nursing homes shall provide contact information to the Senior LinkAge Line for
 122.26 residents identified in paragraph (b), clause (12), to provide long-term care options counseling
 122.27 pursuant to paragraph (b), clause (11). The contact information for residents shall include
 122.28 all information reasonably necessary to contact residents, including first and last names,
 122.29 permanent and temporary addresses, telephone numbers, and e-mail addresses.

122.30 (d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer
 122.31 who receives long-term care options counseling under paragraph (b), clause (12) or (13),
 122.32 and who uses an unpaid caregiver to the self-directed caregiver service under subdivision
 122.33 12.

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

123.1 Sec. 5. Minnesota Statutes 2016, section 256.975, is amended by adding a subdivision to
123.2 read:

123.3 Subd. 12. **Self-directed caregiver grants.** Beginning on July 1, 2019, the Minnesota
123.4 Board on Aging shall administer self-directed caregiver grants to support at risk family
123.5 caregivers of older adults or others eligible under the Older Americans Act of 1965, United
123.6 States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in
123.7 the caregivers' roles so older adults can remain at home longer. The board shall give priority
123.8 to consumers referred under section 256.975, subdivision 7, paragraph (d).

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

123.10 Sec. 6. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

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

123.20 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
123.21 assessors to conduct the assessment. For a person with complex health care needs, a public
123.22 health or registered nurse from the team must be consulted.

123.23 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
123.24 be used to complete a comprehensive, person-centered assessment. The assessment must
123.25 include the health, psychological, functional, environmental, and social needs of the
123.26 individual necessary to develop a community support plan that meets the individual's needs
123.27 and preferences.

123.28 (d) The assessment must be conducted in a face-to-face interview with the person being
123.29 assessed and the person's legal representative. At the request of the person, other individuals
123.30 may participate in the assessment to provide information on the needs, strengths, and
123.31 preferences of the person necessary to develop a community support plan that ensures the
123.32 person's health and safety. Except for legal representatives or family members invited by
123.33 the person, persons participating in the assessment may not be a provider of service or have

124.1 any financial interest in the provision of services. For persons who are to be assessed for
124.2 elderly waiver customized living or adult day services under section 256B.0915, with the
124.3 permission of the person being assessed or the person's designated or legal representative,
124.4 the client's current or proposed provider of services may submit a copy of the provider's
124.5 nursing assessment or written report outlining its recommendations regarding the client's
124.6 care needs. The person conducting the assessment must notify the provider of the date by
124.7 which this information is to be submitted. This information shall be provided to the person
124.8 conducting the assessment prior to the assessment. For a person who is to be assessed for
124.9 waiver services under section 256B.092 or 256B.49, with the permission of the person being
124.10 assessed or the person's designated legal representative, the person's current provider of
124.11 services may submit a written report outlining recommendations regarding the person's care
124.12 needs prepared by a direct service employee with at least 20 hours of service to that client.
124.13 The person conducting the assessment or reassessment must notify the provider of the date
124.14 by which this information is to be submitted. This information shall be provided to the
124.15 person conducting the assessment and the person or the person's legal representative, and
124.16 must be considered prior to the finalization of the assessment or reassessment.

124.17 (e) The person or the person's legal representative must be provided with a written
124.18 community support plan within 40 calendar days of the assessment visit, regardless of
124.19 whether the individual is eligible for Minnesota health care programs.

124.20 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
124.21 provider who submitted information under paragraph (d) shall receive a copy of the
124.22 assessment, the final written community support plan when available, the case mix level,
124.23 and the Residential Services Workbook.

124.24 (g) The written community support plan must include:

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

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

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

124.30 (4) referral information; and

124.31 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

125.29 (4) the role of long-term care consultation assessment and support planning in eligibility
125.30 determination for waiver and alternative care programs, and state plan home care, case
125.31 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
125.32 and (b);

125.33 (5) information about Minnesota health care programs;

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

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

126.4 (8) the certified assessor's decision regarding the person's need for institutional level of
126.5 care as determined under criteria established in subdivision 4e and the certified assessor's
126.6 decision regarding eligibility for all services and programs as defined in subdivision 1a,
126.7 paragraphs (a), clause (6), and (b); and

126.8 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
126.9 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
126.10 (8), and (b), and incorporating the decision regarding the need for institutional level of care
126.11 or the lead agency's final decisions regarding public programs eligibility according to section
126.12 256.045, subdivision 3.

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

126.18 ~~(j)~~ (l) The effective eligibility start date for programs in paragraph ~~(j)~~(k) can never be
126.19 prior to the date of assessment. If an assessment was completed more than 60 days before
126.20 the effective waiver or alternative care program eligibility start date, assessment and support
126.21 plan information must be updated and documented in the department's Medicaid Management
126.22 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
126.23 state plan services, the effective date of eligibility for programs included in paragraph ~~(j)~~
126.24 (k) cannot be prior to the date the most recent updated assessment is completed.

126.25 (m) If an eligibility update is completed within 90 days of the previous face-to-face
126.26 assessment and documented in the department's Medicaid Management Information System
126.27 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
126.28 of the previous face-to-face assessment when all other eligibility requirements are met.

126.29 Sec. 7. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

126.30 Subdivision 1. **Authority.** (a) The commissioner is authorized to apply for a home and
126.31 community-based services waiver for the elderly, authorized under section 1915(c) of the
126.32 Social Security Act, in order to obtain federal financial participation to expand the availability
126.33 of services for persons who are eligible for medical assistance. The commissioner may

127.1 apply for additional waivers or pursue other federal financial participation which is
127.2 advantageous to the state for funding home care services for the frail elderly who are eligible
127.3 for medical assistance.

127.4 (b) The provision of waived services to elderly and disabled medical assistance
127.5 recipients must comply with the criteria for service definitions and provider standards
127.6 approved in the waiver.

127.7 Sec. 8. Minnesota Statutes 2016, section 256B.0915, subdivision 3a, is amended to read:

127.8 Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal
127.9 year in which the resident assessment system as described in section ~~256B.438~~ 256R.17 for
127.10 nursing home rate determination is implemented and the first day of each subsequent state
127.11 fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver
127.12 client shall be the monthly limit of the case mix resident class to which the waiver client
127.13 would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the
127.14 last day of the previous state fiscal year, adjusted by any legislatively adopted home and
127.15 community-based services percentage rate adjustment. If a legislatively authorized increase
127.16 is service-specific, the monthly cost limit shall be adjusted based on the overall average
127.17 increase to the elderly waiver program.

127.18 (b) The monthly limit for the cost of waived services under paragraph (a) to an
127.19 individual elderly waiver client assigned to a case mix classification A with:

127.20 (1) no dependencies in activities of daily living; or

127.21 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating when
127.22 the dependency score in eating is three or greater as determined by an assessment performed
127.23 under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new
127.24 participants enrolled in the program on or after July 1, 2011. This monthly limit shall be
127.25 applied to all other participants who meet this criteria at reassessment. This monthly limit
127.26 shall be increased annually as described in paragraphs (a) and (e).

127.27 (c) If extended medical supplies and equipment or environmental modifications are or
127.28 will be purchased for an elderly waiver client, the costs may be prorated for up to 12
127.29 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's
127.30 waived services exceeds the monthly limit established in paragraph (a), (b), (d), or (e),
127.31 the annual cost of all waived services shall be determined. In this event, the annual cost
127.32 of all waived services shall not exceed 12 times the monthly limit of waived services
127.33 as described in paragraph (a), (b), (d), or (e).

128.1 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including any
128.2 necessary home care services described in section 256B.0651, subdivision 2, for individuals
128.3 who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1,
128.4 paragraph (g), shall be the average of the monthly medical assistance amount established
128.5 for home care services as described in section 256B.0652, subdivision 7, and the annual
128.6 average contracted amount established by the commissioner for nursing facility services
128.7 for ventilator-dependent individuals. This monthly limit shall be increased annually as
128.8 described in paragraphs (a) and (e).

128.9 (e) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, the monthly
128.10 cost limits for elderly waiver services in effect on the previous ~~June 30~~ December 31 shall
128.11 be increased by the difference between any legislatively adopted home and community-based
128.12 provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and
128.13 the average statewide percentage increase in nursing facility operating payment rates under
128.14 ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January
128.15 1. This paragraph shall only apply if the average statewide percentage increase in nursing
128.16 facility operating payment rates is greater than any legislatively adopted home and
128.17 community-based provider rate increases effective on ~~July~~ January 1, or occurring since
128.18 the previous ~~July~~ January 1.

128.19 Sec. 9. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

128.20 Subd. 3e. **Customized living service rate.** (a) Payment for customized living services
128.21 shall be a monthly rate authorized by the lead agency within the parameters established by
128.22 the commissioner. The payment agreement must delineate the amount of each component
128.23 service included in the recipient's customized living service plan. The lead agency, with
128.24 input from the provider of customized living services, shall ensure that there is a documented
128.25 need within the parameters established by the commissioner for all component customized
128.26 living services authorized.

128.27 (b) The payment rate must be based on the amount of component services to be provided
128.28 utilizing component rates established by the commissioner. Counties and tribes shall use
128.29 tools issued by the commissioner to develop and document customized living service plans
128.30 and rates.

128.31 (c) Component service rates must not exceed payment rates for comparable elderly
128.32 waiver or medical assistance services and must reflect economies of scale. Customized
128.33 living services must not include rent or raw food costs.

129.1 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
 129.2 individualized monthly authorized payment for the customized living service plan shall not
 129.3 exceed 50 percent of the ~~greater of either the statewide or any of the geographic groups'~~
 129.4 weighted average monthly nursing facility rate of the case mix resident class to which the
 129.5 elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051
 129.6 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph
 129.7 (a). ~~Effective On July 1 of the state fiscal~~ each year in which the resident assessment system
 129.8 ~~as described in section 256B.438 for nursing home rate determination is implemented and~~
 129.9 ~~July 1 of each subsequent state fiscal year,~~ the individualized monthly authorized payment
 129.10 for the services described in this clause shall not exceed the limit which was in effect on
 129.11 June 30 of the previous state fiscal year updated annually based on legislatively adopted
 129.12 changes to all service rate maximums for home and community-based service providers.

129.13 (e) For rates effective on or after January 1, 2022, the elderly waiver payment for
 129.14 customized living services includes a cognitive and behavioral needs factor equal to an
 129.15 additional 15 percent applied to the component service rates for a client:

129.16 (1) for whom the total monthly hours for customized living services divided by 30.4 is
 129.17 less than 3.62; and

129.18 (2) is determined, based on responses to questions 45 and 51 of the Minnesota long-term
 129.19 care consultation assessment form, to have either:

129.20 (i) wandering or orientation issues; or

129.21 (ii) anxiety, verbal aggression, physical aggression, repetitive behavior, agitation,
 129.22 self-injurious behavior, or behavior related to property destruction.

129.23 ~~(e) Effective July 1, 2011,~~ (f) The individualized monthly payment for the customized
 129.24 living service plan for individuals described in subdivision 3a, paragraph (b), must be the
 129.25 monthly authorized payment limit for customized living for individuals classified as case
 129.26 mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled
 129.27 in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a,
 129.28 paragraph (b). This monthly limit also applies to all other participants who meet the criteria
 129.29 described in subdivision 3a, paragraph (b), at reassessment.

129.30 ~~(f)~~ (g) Customized living services are delivered by a provider licensed by the Department
 129.31 of Health as a class A or class F home care provider and provided in a building that is
 129.32 registered as a housing with services establishment under chapter 144D. Licensed home
 129.33 care providers are subject to section 256B.0651, subdivision 14.

130.1 ~~(g)~~ (h) A provider may not bill or otherwise charge an elderly waiver participant or their
 130.2 family for additional units of any allowable component service beyond those available under
 130.3 the service rate limits described in paragraph ~~(d)~~ (e), nor for additional units of any allowable
 130.4 component service beyond those approved in the service plan by the lead agency.

130.5 ~~(h)~~ (i) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
 130.6 individualized service rate limits for customized living services under this subdivision shall
 130.7 be increased by the difference between any legislatively adopted home and community-based
 130.8 provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and
 130.9 the average statewide percentage increase in nursing facility operating payment rates under
 130.10 sections 256B.431, and 256B.434, and ~~256B.441~~ chapter 256R, effective the previous
 130.11 January 1. This paragraph shall only apply if the average statewide percentage increase in
 130.12 nursing facility operating payment rates is greater than any legislatively adopted home and
 130.13 community-based provider rate increases effective on ~~July~~ January 1, or occurring since
 130.14 the previous ~~July~~ January 1.

130.15 Sec. 10. Minnesota Statutes 2016, section 256B.0915, subdivision 3h, is amended to read:

130.16 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment
 130.17 rate for 24-hour customized living services is a monthly rate authorized by the lead agency
 130.18 within the parameters established by the commissioner of human services. The payment
 130.19 agreement must delineate the amount of each component service included in each recipient's
 130.20 customized living service plan. The lead agency, with input from the provider of customized
 130.21 living services, shall ensure that there is a documented need within the parameters established
 130.22 by the commissioner for all component customized living services authorized. The lead
 130.23 agency shall not authorize 24-hour customized living services unless there is a documented
 130.24 need for 24-hour supervision.

130.25 (b) For purposes of this section, "24-hour supervision" means that the recipient requires
 130.26 assistance due to needs related to one or more of the following:

130.27 (1) intermittent assistance with toileting, positioning, or transferring;

130.28 (2) cognitive or behavioral issues;

130.29 (3) a medical condition that requires clinical monitoring; or

130.30 (4) for all new participants enrolled in the program on or after July 1, 2011, and all other
 130.31 participants at their first reassessment after July 1, 2011, dependency in at least three of the
 130.32 following activities of daily living as determined by assessment under section 256B.0911:
 130.33 bathing; dressing; grooming; walking; or eating when the dependency score in eating is

131.1 three or greater; and needs medication management and at least 50 hours of service per
131.2 month. The lead agency shall ensure that the frequency and mode of supervision of the
131.3 recipient and the qualifications of staff providing supervision are described and meet the
131.4 needs of the recipient.

131.5 (c) The payment rate for 24-hour customized living services must be based on the amount
131.6 of component services to be provided utilizing component rates established by the
131.7 commissioner. Counties and tribes will use tools issued by the commissioner to develop
131.8 and document customized living plans and authorize rates.

131.9 (d) Component service rates must not exceed payment rates for comparable elderly
131.10 waiver or medical assistance services and must reflect economies of scale.

131.11 (e) The individually authorized 24-hour customized living payments, in combination
131.12 with the payment for other elderly waiver services, including case management, must not
131.13 exceed the recipient's community budget cap specified in subdivision 3a. Customized living
131.14 services must not include rent or raw food costs.

131.15 (f) The individually authorized 24-hour customized living payment rates shall not exceed
131.16 the 95 percentile of statewide monthly authorizations for 24-hour customized living services
131.17 in effect and in the Medicaid management information systems on March 31, 2009, for each
131.18 case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which
131.19 elderly waiver service clients are assigned. When there are fewer than 50 authorizations in
131.20 effect in the case mix resident class, the commissioner shall multiply the calculated service
131.21 payment rate maximum for the A classification by the standard weight for that classification
131.22 under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment
131.23 rate maximum. Service payment rate maximums shall be updated annually based on
131.24 legislatively adopted changes to all service rates for home and community-based service
131.25 providers.

131.26 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may
131.27 establish alternative payment rate systems for 24-hour customized living services in housing
131.28 with services establishments which are freestanding buildings with a capacity of 16 or fewer,
131.29 by applying a single hourly rate for covered component services provided in either:

131.30 (1) licensed corporate adult foster homes; or

131.31 (2) specialized dementia care units which meet the requirements of section 144D.065
131.32 and in which:

131.33 (i) each resident is offered the option of having their own apartment; or

132.1 (ii) the units are licensed as board and lodge establishments with maximum capacity of
 132.2 eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
 132.3 subparts 1, 2, 3, and 4, item A.

132.4 (h) Twenty-four-hour customized living services are delivered by a provider licensed
 132.5 by the Department of Health as a class A or class F home care provider and provided in a
 132.6 building that is registered as a housing with services establishment under chapter 144D.
 132.7 Licensed home care providers are subject to section 256B.0651, subdivision 14.

132.8 (i) A provider may not bill or otherwise charge an elderly waiver participant or their
 132.9 family for additional units of any allowable component service beyond those available under
 132.10 the service rate limits described in paragraph (e), nor for additional units of any allowable
 132.11 component service beyond those approved in the service plan by the lead agency.

132.12 (j) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
 132.13 individualized service rate limits for 24-hour customized living services under this
 132.14 subdivision shall be increased by the difference between any legislatively adopted home
 132.15 and community-based provider rate increases effective on ~~July~~ January 1 or since the previous
 132.16 ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating
 132.17 payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective
 132.18 the previous January 1. This paragraph shall only apply if the average statewide percentage
 132.19 increase in nursing facility operating payment rates is greater than any legislatively adopted
 132.20 home and community-based provider rate increases effective on ~~July~~ January 1, or occurring
 132.21 since the previous ~~July~~ January 1.

132.22 Sec. 11. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

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

132.32 (b) Regardless of other assessments identified in section 144.0724, subdivision 4, as
 132.33 appropriate to determine nursing facility level of care for purposes of medical assistance
 132.34 payment for nursing facility services, only face-to-face assessments conducted according

133.1 to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care
133.2 determination will be accepted for purposes of initial and ongoing access to waiver service
133.3 payment.

133.4 (c) The lead agency shall conduct a change-in-condition reassessment before the annual
133.5 reassessment in cases where a client's condition changed due to a major health event, an
133.6 emerging need or risk, worsening health condition, or cases where the current services do
133.7 not meet the client's needs. A change-in-condition reassessment may be initiated by the lead
133.8 agency, or it may be requested by the client or requested on the client's behalf by another
133.9 party, such as a provider of services. The lead agency shall complete a change-in-condition
133.10 reassessment no later than 20 calendar days from the request. The lead agency shall conduct
133.11 these assessments in a timely manner and expedite urgent requests. The lead agency shall
133.12 evaluate urgent requests based on the client's needs and risk to the client if a reassessment
133.13 is not completed.

133.14 Sec. 12. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
133.15 to read:

133.16 Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12
133.17 to 16 apply to elderly waiver and elderly waiver customized living under this section,
133.18 alternative care under section 256B.0913, essential community supports under section
133.19 256B.0922, and community access for disability inclusion customized living, brain injury
133.20 customized living, and elderly waiver foster care and residential care.

133.21 Sec. 13. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
133.22 to read:

133.23 Subd. 12. **Payment rates; phase-in.** (a) Effective January 1, 2018, through December
133.24 31, 2019, all rates and rate components for services under subdivision 11 shall be the sum
133.25 of 12 percent of the rates calculated under subdivisions 13 to 16 and 88 percent of the rates
133.26 calculated using the rate methodology in effect as of June 30, 2017.

133.27 (b) Effective January 1, 2020, through December 30, 2021, all rates and rate components
133.28 for services under subdivision 11 shall be the sum of 20 percent of the rates calculated under
133.29 subdivisions 13 to 16 and 80 percent of the rates calculated using the rate methodology in
133.30 effect as of June 30, 2017.

133.31 (c) Effective January 1, 2022, all rates and rate components shall be calculated according
133.32 to subdivisions 13 to 16.

134.1 Sec. 14. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
134.2 to read:

134.3 Subd. 13. **Payment rates; establishment.** (a) The commissioner shall use standard
134.4 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
134.5 the most recent edition of the Occupational Handbook and data from the most recent and
134.6 available nursing facility cost report, to establish rates and component rates every January
134.7 1 using Minnesota-specific wages taken from job descriptions.

134.8 (b) In creating the rates and component rates, the commissioner shall establish a base
134.9 wage calculation for each component service and value, and add the following factors:

134.10 (1) payroll taxes and benefits;

134.11 (2) general and administrative;

134.12 (3) program plan support;

134.13 (4) registered nurse management and supervision; and

134.14 (5) social worker supervision.

134.15 Sec. 15. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
134.16 to read:

134.17 Subd. 14. **Payment rates; base wage index.** (a) Base wages are calculated for customized
134.18 living, foster care, and residential care component services as follows:

134.19 (1) the home management and support services base wage equals 33.33 percent of the
134.20 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
134.21 care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington,
134.22 MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and
134.23 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage
134.24 for maids and housekeeping cleaners (SOC code 37-2012);

134.25 (2) the home care aide base wage equals 50 percent of the Minneapolis-St.
134.26 Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code
134.27 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
134.28 average wage for nursing assistants (SOC code 31-1014);

134.29 (3) the home health aide base wage equals 20 percent of the Minneapolis-St.
134.30 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed
134.31 vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.

135.1 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
135.2 31-1014); and

135.3 (4) the medication setups by licensed practical nurse base wage equals ten percent of
135.4 the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
135.5 and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St.
135.6 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
135.7 29-1141).

135.8 (b) Base wages are calculated for the following services as follows:

135.9 (1) the chore services base wage equals 100 percent of the Minneapolis-St.
135.10 Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping
135.11 workers (SOC code 37-3011);

135.12 (2) the companion services base wage equals 50 percent of the Minneapolis-St.
135.13 Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC
135.14 code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
135.15 average wage for maids and housekeeping cleaners (SOC code 37-2012);

135.16 (3) the homemaker services and assistance with personal care base wage equals 60
135.17 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
135.18 personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St.
135.19 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
135.20 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
135.21 average wage for maids and housekeeping cleaners (SOC code 37-2012);

135.22 (4) the homemaker services and cleaning base wage equals 60 percent of the
135.23 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
135.24 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
135.25 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
135.26 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
135.27 housekeeping cleaners (SOC code 37-2012);

135.28 (5) the homemaker services and home management base wage equals 60 percent of the
135.29 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
135.30 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
135.31 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
135.32 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
135.33 housekeeping cleaners (SOC code 37-2012);

136.1 (6) the in-home respite care services base wage equals five percent of the Minneapolis-St.
 136.2 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
 136.3 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average
 136.4 wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St.
 136.5 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed
 136.6 vocational nurses (SOC code 29-2061);

136.7 (7) the out-of-home respite care services base wage equals five percent of the
 136.8 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses
 136.9 (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
 136.10 average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
 136.11 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
 136.12 and licensed vocational nurses (SOC code 29-2061); and

136.13 (8) the individual community living support base wage equals 20 percent of the
 136.14 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
 136.15 and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.
 136.16 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
 136.17 31-1014).

136.18 (c) Base wages are calculated for the following values as follows:

136.19 (1) the registered nurse base wage equals 100 percent of the Minneapolis-St.
 136.20 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
 136.21 29-1141); and

136.22 (2) the social worker base wage equals 100 percent of the Minneapolis-St.
 136.23 Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social
 136.24 workers (SOC code 21-1022).

136.25 (d) If any of the SOC codes and positions are no longer available, the commissioner
 136.26 shall, in consultation with stakeholders, select a new SOC code and position that is the
 136.27 closest match to the previously used SOC position.

136.28 Sec. 16. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
 136.29 to read:

136.30 Subd. 15. **Payment rates; factors.** The commissioner shall use the following factors:

136.31 (1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits
 136.32 divided by the sum of all salaries for all nursing facilities on the most recent and available
 136.33 cost report;

137.1 (2) the general and administrative factor is the sum of net general and administrative
137.2 expenses minus administrative salaries divided by total operating expenses for all nursing
137.3 facilities on the most recent and available cost report;

137.4 (3) the program plan support factor is defined as the direct service staff needed to provide
137.5 support for the home and community-based service when not engaged in direct contact with
137.6 clients. Based on the 2016 Non-Wage Provider Costs in Home and Community-Based
137.7 Disability Waiver Services Report, this factor equals 12.8 percent;

137.8 (4) the registered nurse management and supervision factor equals 15 percent of the
137.9 product of the position's base wage and the sum of the factors in clauses (1) to (3); and

137.10 (5) the social worker supervision factor equals 15 percent of the product of the position's
137.11 base wage and the sum of the factors in clauses (1) to (3).

137.12 Sec. 17. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
137.13 to read:

137.14 Subd. 16. **Payment rates; component rates.** (a) For the purposes of this subdivision,
137.15 the "adjusted base wage" for a position equals the position's base wage plus:

137.16 (1) the position's base wage multiplied by the payroll taxes and benefits factor;

137.17 (2) the position's base wage multiplied by the general and administrative factor; and

137.18 (3) the position's base wage multiplied by the program plan support factor.

137.19 (b) For medication setups by licensed nurse, registered nurse, and social worker services,
137.20 the component rate for each service equals the respective position's adjusted base wage.

137.21 (c) For home management and support services, home care aide, and home health aide
137.22 services, the component rate for each service equals the respective position's adjusted base
137.23 wage plus the registered nurse management and supervision factor.

137.24 (d) The home management and support services component rate shall be used for payment
137.25 for socialization and transportation component rates under elderly waiver customized living.

137.26 (e) The 15-minute unit rates for chore services and companion services are calculated
137.27 as follows:

137.28 (1) sum the adjusted base wage for the respective position and the social worker factor;
137.29 and

137.30 (2) divide the result of clause (1) by four.

138.1 (f) The 15-minute unit rates for homemaker services and assistance with personal care,
138.2 homemaker services and cleaning, and homemaker services and home management are
138.3 calculated as follows:

138.4 (1) sum the adjusted base wage for the respective position and the registered nurse
138.5 management and supervision factor; and

138.6 (2) divide the result of clause (1) by four.

138.7 (g) The 15-minute unit rate for in-home respite care services is calculated as follows:

138.8 (1) sum the adjusted base wage for in-home respite care services and the registered nurse
138.9 management and supervision factor; and

138.10 (2) divide the result of clause (1) by four.

138.11 (h) The in-home respite care services daily rate equals the in-home respite care services
138.12 15-minute unit rate multiplied by 18.

138.13 (i) The 15-minute unit rate for out-of-home respite care is calculated as follows:

138.14 (1) sum the out-of-home respite care services adjusted base wage and the registered
138.15 nurse management and supervision factor; and

138.16 (2) divide the result of clause (1) by four.

138.17 (j) The out-of-home respite care services daily rate equals the out-of-home respite care
138.18 services 15-minute unit rate multiplied by 18.

138.19 (k) The individual community living support rate is calculated as follows:

138.20 (1) sum the adjusted base wage for the home care aide rate in subdivision 14, paragraph
138.21 (a), clause (2), and the social worker factor; and

138.22 (2) divide the result of clause (1) by four.

138.23 (l) The home delivered meals rate equals \$9.30. Beginning July 1, 2018, the commissioner
138.24 shall increase the home delivered meals rate every July 1 by the percent increase in the
138.25 nursing facility dietary per diem using the two most recent nursing facility cost reports.

138.26 (m) The adult day services rate is based on the home care aide rate in subdivision 14,
138.27 paragraph (a), clause (2), plus the additional factors from subdivision 15, except that the
138.28 general and administrative factor used shall be 20 percent. The nonregistered nurse portion
138.29 of the rate shall be multiplied by 0.25, to reflect an assumed-ratio staffing of one caregiver
138.30 to four clients, and divided by four to determine the 15-minute unit rate. The registered

139.1 nurse portion is divided by four to determine the 15-minute unit rate and \$0.63 per 15-minute
 139.2 unit is added to cover the cost of meals.

139.3 (n) The adult day services bath 15-minute unit rate is the same as the calculation of the
 139.4 adult day services 15-minute unit rate without the adjustment for staffing ratio.

139.5 (o) If a bath is authorized for an adult day services client, at least two 15-minute units
 139.6 must be authorized to allow for adequate time to meet client needs. Adult day services may
 139.7 be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver
 139.8 needs.

139.9 Sec. 18. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
 139.10 to read:

139.11 Subd. 17. **Evaluation of rate methodology.** The commissioner, in consultation with
 139.12 stakeholders, shall conduct a study to evaluate the following:

139.13 (1) base wages in subdivision 14, to determine if the standard occupational classification
 139.14 codes for each rate and component rate are an appropriate representation of staff who deliver
 139.15 the services; and

139.16 (2) factors in subdivision 15, and adjusted base wage calculation in subdivision 16, to
 139.17 determine if the factors and calculations appropriately address nonwage provider costs.

139.18 By January 1, 2019, the commissioner shall submit a report to the legislature on the
 139.19 changes to the rate methodology in this statute, based on the results of the evaluation. Where
 139.20 feasible, the report shall address the impact of the new rates on the workforce situation and
 139.21 client access to services. The report should include any changes to the rate calculations
 139.22 methods that the commissioner recommends.

139.23 Sec. 19. Minnesota Statutes 2016, section 256B.0922, subdivision 1, is amended to read:

139.24 **Subdivision 1. Essential community supports.** (a) The purpose of the essential
 139.25 community supports program is to provide targeted services to persons age 65 and older
 139.26 who need essential community support, but whose needs do not meet the level of care
 139.27 required for nursing facility placement under section 144.0724, subdivision 11.

139.28 (b) Essential community supports are available not to exceed ~~\$400~~ \$600 per person per
 139.29 month. Essential community supports may be used as authorized within an authorization
 139.30 period not to exceed 12 months. Services must be available to a person who:

139.31 (1) is age 65 or older;

- 140.1 (2) is not eligible for medical assistance;
- 140.2 (3) has received a community assessment under section 256B.0911, subdivision 3a or
140.3 3b, and does not require the level of care provided in a nursing facility;
- 140.4 (4) meets the financial eligibility criteria for the alternative care program under section
140.5 256B.0913, subdivision 4;
- 140.6 (5) has a community support plan; and
- 140.7 (6) has been determined by a community assessment under section 256B.0911,
140.8 subdivision 3a or 3b, to be a person who would require provision of at least one of the
140.9 following services, as defined in the approved elderly waiver plan, in order to maintain their
140.10 community residence:
- 140.11 (i) adult day services;
- 140.12 (ii) family caregiver support services;
- 140.13 (iii) respite care;
- 140.14 ~~(iii)~~ (iv) homemaker support;
- 140.15 (v) companion services;
- 140.16 ~~(iv)~~ (vi) chores;
- 140.17 ~~(v)~~ (vii) a personal emergency response device or system;
- 140.18 ~~(vi)~~ (viii) home-delivered meals; or
- 140.19 ~~(vii)~~ (ix) community living assistance as defined by the commissioner.
- 140.20 (c) The person receiving any of the essential community supports in this subdivision
140.21 must also receive service coordination, not to exceed \$600 in a 12-month authorization
140.22 period, as part of their community support plan.
- 140.23 (d) A person who has been determined to be eligible for essential community supports
140.24 must be reassessed at least annually and continue to meet the criteria in paragraph (b) to
140.25 remain eligible for essential community supports.
- 140.26 (e) The commissioner is authorized to use federal matching funds for essential community
140.27 supports as necessary and to meet demand for essential community supports as outlined in
140.28 subdivision 2, and that amount of federal funds is appropriated to the commissioner for this
140.29 purpose.

141.1 Sec. 20. Minnesota Statutes 2016, section 256B.431, subdivision 10, is amended to read:

141.2 Subd. 10. **Property rate adjustments and construction projects.** A nursing facility
141.3 completing a construction project that is eligible for a rate adjustment under section
141.4 256B.434, subdivision 4f, and that was not approved through the moratorium exception
141.5 process in section 144A.073 must request from the commissioner a property-related payment
141.6 rate adjustment. ~~If the request is made within 60 days after the construction project's~~
141.7 ~~completion date,~~ The effective date of the rate adjustment is the first of the month of January
141.8 or July, whichever occurs first following both the construction project's completion date
141.9 and submission of the provider's rate adjustment request. ~~If the request is made more than~~
141.10 ~~60 days after the completion date, the rate adjustment is effective on the first of the month~~
141.11 ~~following the request.~~ The commissioner shall provide a rate notice reflecting the allowable
141.12 costs within 60 days after receiving all the necessary information to compute the rate
141.13 adjustment. No sooner than the effective date of the rate adjustment for the construction
141.14 project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any
141.15 amounts collected from private pay residents in excess of the allowable rate must be repaid
141.16 to private pay residents with interest at the rate used by the commissioner of revenue for
141.17 the late payment of taxes and in effect on the date the rate increase is effective. Construction
141.18 projects with completion dates within one year of the completion date associated with the
141.19 property rate adjustment request and phased projects with project completion dates within
141.20 three years of the last phase of the phased project must be aggregated for purposes of the
141.21 minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section
141.22 144A.071, subdivision 2. "Construction project" and "project construction costs" have the
141.23 meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

141.24 **EFFECTIVE DATE.** This section is effective for projects completed after January 1,
141.25 2018.

141.26 Sec. 21. Minnesota Statutes 2016, section 256B.431, subdivision 16, is amended to read:

141.27 Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning
141.28 after June 30, 1993, if a nursing facility acquires capital assets in connection with a project
141.29 approved under the moratorium exception process in section 144A.073 or in connection
141.30 with an addition to or replacement of buildings, attached fixtures, or land improvements
141.31 for which the total historical cost of those capital asset additions exceeds the lesser of
141.32 \$150,000 or ten percent of the most recent appraised value, the nursing facility shall be
141.33 eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation

142.1 is separate from the determination of the nursing facility's rental rate. An equity incentive
142.2 payment rate as computed under this subdivision is limited to one in a 12-month period.

142.3 (a) An eligible nursing facility shall receive an equity incentive payment rate equal to
142.4 the allowable historical cost of the capital asset acquired, minus the allowable debt directly
142.5 identified to that capital asset, multiplied by the equity incentive factor as described in
142.6 paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under
142.7 subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total
142.8 payment rate and shall be effective the same day as the incremental increase in paragraph
142.9 (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable
142.10 debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080,
142.11 and this section.

142.12 (b) The equity incentive factor shall be determined under clauses (1) to (4):

142.13 (1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the
142.14 capital asset additions referred to in paragraph (a), then cube the quotient,

142.15 (2) subtract the amount calculated in clause (1) from the number one,

142.16 (3) determine the difference between the rental factor and the lesser of two percentage
142.17 points above the posted yield for standard conventional fixed rate mortgages of the Federal
142.18 Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on
142.19 the first day of the month the debt or cost is incurred, or 16 percent,

142.20 (4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

142.21 (c) The equity incentive payment rate shall be limited to the term of the allowable debt
142.22 in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in
142.23 acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The
142.24 sale of a nursing facility under subdivision 14 shall terminate application of the equity
142.25 incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for
142.26 the sale.

142.27 (d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures,
142.28 or land improvements meeting the criteria in this subdivision and not receiving the
142.29 property-related payment rate adjustment in subdivision 17, shall receive the incremental
142.30 increase in the nursing facility's rental rate as determined under Minnesota Rules, parts
142.31 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the
142.32 nursing facility's property-related payment rate. The effective date of this incremental

143.1 increase shall be the first day of the month of January or July, whichever occurs first
143.2 following the ~~month in~~ date on which the addition or replacement is completed.

143.3 **EFFECTIVE DATE.** This section is effective for additions or replacements completed
143.4 after January 1, 2018.

143.5 Sec. 22. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

143.6 Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July
143.7 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway
143.8 shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph
143.9 (c), and calculation of the rental per diem, have those beds given the same effect as if the
143.10 beds had been delicensed so long as the beds remain on layaway. At the time of a layaway,
143.11 a facility may change its single bed election for use in calculating capacity days under
143.12 Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be
143.13 effective the first day of the month of January or July, whichever occurs first following the
143.14 ~~month in~~ date on which the layaway of the beds becomes effective under section 144A.071,
143.15 subdivision 4b.

143.16 (b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to
143.17 the contrary under section 256B.434, a nursing facility reimbursed under that section ~~which~~
143.18 that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed
143.19 to:

143.20 (1) aggregate the applicable investment per bed limits based on the number of beds
143.21 licensed immediately prior to entering the alternative payment system;

143.22 (2) retain or change the facility's single bed election for use in calculating capacity days
143.23 under Minnesota Rules, part 9549.0060, subpart 11; and

143.24 (3) establish capacity days based on the number of beds immediately prior to the layaway
143.25 and the number of beds after the layaway.

143.26 The commissioner shall increase the facility's property payment rate by the incremental
143.27 increase in the rental per diem resulting from the recalculation of the facility's rental per
143.28 diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and
143.29 (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
143.30 project after its base year, the base year property rate shall be the moratorium project property
143.31 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
143.32 paragraph (c). The property payment rate increase shall be effective the first day of the

144.1 month of January or July, whichever occurs first following the ~~month in~~ date on which the
144.2 layaway of the beds becomes effective.

144.3 (c) If a nursing facility removes a bed from layaway status in accordance with section
144.4 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the
144.5 number of licensed and certified beds in the facility not on layaway and shall reduce the
144.6 nursing facility's property payment rate in accordance with paragraph (b).

144.7 (d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision
144.8 to the contrary under section 256B.434, a nursing facility reimbursed under that section,
144.9 ~~which~~ that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the
144.10 commissioner of health according to the notice requirements in section 144A.071, subdivision
144.11 4b, shall be allowed to:

144.12 (1) aggregate the applicable investment per bed limits based on the number of beds
144.13 licensed immediately prior to entering the alternative payment system;

144.14 (2) retain or change the facility's single bed election for use in calculating capacity days
144.15 under Minnesota Rules, part 9549.0060, subpart 11; and

144.16 (3) establish capacity days based on the number of beds immediately prior to the
144.17 delicensure and the number of beds after the delicensure.

144.18 The commissioner shall increase the facility's property payment rate by the incremental
144.19 increase in the rental per diem resulting from the recalculation of the facility's rental per
144.20 diem applying only the changes resulting from the delicensure of beds and clauses (1), (2),
144.21 and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
144.22 project after its base year, the base year property rate shall be the moratorium project property
144.23 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
144.24 paragraph (c). The property payment rate increase shall be effective the first day of the
144.25 month of January or July, whichever occurs first following the ~~month in~~ date on which the
144.26 delicensure of the beds becomes effective.

144.27 (e) For nursing facilities reimbursed under this section or section 256B.434, any beds
144.28 placed on layaway shall not be included in calculating facility occupancy as it pertains to
144.29 leave days defined in Minnesota Rules, part 9505.0415.

144.30 (f) For nursing facilities reimbursed under this section or section 256B.434, the rental
144.31 rate calculated after placing beds on layaway may not be less than the rental rate prior to
144.32 placing beds on layaway.

145.1 (g) A nursing facility receiving a rate adjustment as a result of this section shall comply
 145.2 with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

145.3 (h) A facility that does not utilize the space made available as a result of bed layaway
 145.4 or delicensure under this subdivision to reduce the number of beds per room or provide
 145.5 more common space for nursing facility uses or perform other activities related to the
 145.6 operation of the nursing facility shall have its property rate increase calculated under this
 145.7 subdivision reduced by the ratio of the square footage made available that is not used for
 145.8 these purposes to the total square footage made available as a result of bed layaway or
 145.9 delicensure.

145.10 **EFFECTIVE DATE.** This section is effective for layaways occurring after July 1, 2017.

145.11 Sec. 23. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

145.12 Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning
 145.13 on and after January 1, 2019, a nursing facility's ~~ease mix~~ property payment rates rate for
 145.14 the second and subsequent years of a facility's contract under this section are the previous
 145.15 rate year's ~~contract~~ property payment rates rate plus an inflation adjustment ~~and, for facilities~~
 145.16 ~~reimbursed under this section or section 256B.431, an adjustment to include the cost of any~~
 145.17 ~~increase in Health Department licensing fees for the facility taking effect on or after July~~
 145.18 ~~1, 2001.~~ The index for the inflation adjustment must be based on the change in the Consumer
 145.19 Price Index-All Items (United States City average) (CPI-U) forecasted by the ~~commissioner~~
 145.20 ~~of management and budget's national economic consultant~~ Reports and Forecasts Division
 145.21 of the Department of Human Services, as forecasted in the fourth quarter of the calendar
 145.22 year preceding the rate year. The inflation adjustment must be based on the 12-month period
 145.23 from the midpoint of the previous rate year to the midpoint of the rate year for which the
 145.24 rate is being determined. ~~For the rate years beginning on July 1, 1999, July 1, 2000, July 1,~~
 145.25 ~~2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July~~
 145.26 ~~1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the~~
 145.27 ~~property-related payment rate. For the rate years beginning on October 1, 2011, October 1,~~
 145.28 ~~2012, October 1, 2013, October 1, 2014, October 1, 2015, January 1, 2016, and January 1,~~
 145.29 ~~2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005,~~
 145.30 ~~adjustment to the property payment rate under this section and section 256B.431 shall be~~
 145.31 ~~effective on October 1. In determining the amount of the property-related payment rate~~
 145.32 ~~adjustment under this paragraph, the commissioner shall determine the proportion of the~~
 145.33 ~~facility's rates that are property-related based on the facility's most recent cost report.~~

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

146.1 Sec. 24. Minnesota Statutes 2016, section 256B.434, subdivision 4f, is amended to read:

146.2 Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a)

146.3 Effective October 1, 2006, facilities reimbursed under this section may receive a property
146.4 rate adjustment for construction projects exceeding the threshold in section 256B.431,
146.5 subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For
146.6 these projects, capital assets purchased shall be counted as construction project costs for a
146.7 rate adjustment request made by a facility if they are: (1) purchased within 24 months of
146.8 the completion of the construction project; (2) purchased after the completion date of any
146.9 prior construction project; and (3) are not purchased prior to July 14, 2005. Except as
146.10 otherwise provided in this subdivision, the definitions, rate calculation methods, and
146.11 principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to
146.12 9549.0080, shall be used to calculate rate adjustments for allowable construction projects
146.13 under this subdivision and section 144A.073. Facilities completing construction projects
146.14 between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment
146.15 effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible
146.16 for a property rate adjustment effective on the first day of the month following the completion
146.17 date. Facilities completing projects after January 1, 2018, are eligible for a property rate
146.18 adjustment effective on the first day of the month of January or July, whichever occurs
146.19 immediately following the completion date.

146.20 (b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under
146.21 section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a
146.22 construction project on or after October 1, 2004, and do not have a contract under subdivision
146.23 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431,
146.24 subdivision 10, through September 30, 2006. If the request results in the commissioner
146.25 determining a rate adjustment is allowable, the rate adjustment is effective on the first of
146.26 the month following project completion. These facilities shall be allowed to accumulate
146.27 construction project costs for the period October 1, 2004, to September 30, 2006.

146.28 (c) Facilities shall be allowed construction project rate adjustments no sooner than 12
146.29 months after completing a previous construction project. Facilities must request the rate
146.30 adjustment according to section 256B.431, subdivision 10.

146.31 (d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060,
146.32 subpart 11. For rate calculations under this section, the number of licensed beds in the
146.33 nursing facility shall be the number existing after the construction project is completed and
146.34 the number of days in the nursing facility's reporting period shall be 365.

147.1 (e) The value of assets to be recognized for a total replacement project as defined in
147.2 section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value
147.3 of assets to be recognized for all other projects shall be computed as described in clause
147.4 (2).

147.5 (1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
147.6 number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the
147.7 maximum amount of assets allowable in a facility's property rate calculation. If a facility's
147.8 current request for a rate adjustment results from the completion of a construction project
147.9 that was previously approved under section 144A.073, the assets to be used in the rate
147.10 calculation cannot exceed the lesser of the amount determined under sections 144A.071,
147.11 subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction
147.12 project. A current request that is not the result of a project under section 144A.073 cannot
147.13 exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits
147.14 must be deducted from the cost of the construction project.

147.15 (2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
147.16 number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be
147.17 used to compute the maximum amount of assets allowable in a facility's property rate
147.18 calculation.

147.19 (ii) The value of a facility's assets to be compared to the amount in item (i) begins with
147.20 the total appraised value from the last rate notice a facility received when its rates were set
147.21 under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value
147.22 shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each
147.23 rate year the facility received an inflation factor on its property-related rate when its rates
147.24 were set under this section. The value of assets listed as previous capital additions, capital
147.25 additions, and special projects on the facility's base year rate notice and the value of assets
147.26 related to a construction project for which the facility received a rate adjustment when its
147.27 rates were determined under this section shall be added to the indexed appraised value.

147.28 (iii) The maximum amount of assets to be recognized in computing a facility's rate
147.29 adjustment after a project is completed is the lesser of the aggregate replacement-cost-new
147.30 limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the
147.31 construction project.

147.32 (iv) If a facility's current request for a rate adjustment results from the completion of a
147.33 construction project that was previously approved under section 144A.073, the assets to be
147.34 added to the rate calculation cannot exceed the lesser of the amount determined under

148.1 sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable
148.2 costs of the construction project. A current request that is not the result of a project under
148.3 section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2,
148.4 paragraph (a). Assets disposed of as a result of a construction project and applicable credits
148.5 must be deducted from the cost of the construction project.

148.6 (f) For construction projects approved under section 144A.073, allowable debt may
148.7 never exceed the lesser of the cost of the assets purchased, the threshold limit in section
148.8 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital
148.9 debt.

148.10 (g) For construction projects that were not approved under section 144A.073, allowable
148.11 debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such
148.12 construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously
148.13 existing capital debt. Amounts of debt taken out that exceed the costs of a construction
148.14 project shall not be allowed regardless of the use of the funds.

148.15 For all construction projects being recognized, interest expense and average debt shall
148.16 be computed based on the first 12 months following project completion. "Previously existing
148.17 capital debt" means capital debt recognized on the last rate determined under section
148.18 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt
148.19 recognized for a construction project for which the facility received a rate adjustment when
148.20 its rates were determined under this section.

148.21 For a total replacement project as defined in section 256B.431, subdivision 17d, the
148.22 value of previously existing capital debt shall be zero.

148.23 (h) In addition to the interest expense allowed from the application of paragraph (f), the
148.24 amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and
148.25 (3), will be added to interest expense.

148.26 (i) The equity portion of the construction project shall be computed as the allowable
148.27 assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be
148.28 multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added.
148.29 This sum must be divided by 95 percent of capacity days to compute the construction project
148.30 rate adjustment.

148.31 (j) For projects that are not a total replacement of a nursing facility, the amount in
148.32 paragraph (i) is adjusted for nonreimbursable areas and then added to the current property
148.33 payment rate of the facility.

149.1 (k) For projects that are a total replacement of a nursing facility, the amount in paragraph
 149.2 (i) becomes the new property payment rate after being adjusted for nonreimbursable areas.
 149.3 Any amounts existing in a facility's rate before the effective date of the construction project
 149.4 for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements
 149.5 under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431,
 149.6 subdivision 19, shall be removed from the facility's rates.

149.7 (l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060,
 149.8 subpart 10, as the result of construction projects under this section. Allowable equipment
 149.9 shall be included in the construction project costs.

149.10 (m) Capital assets purchased after the completion date of a construction project shall be
 149.11 counted as construction project costs for any future rate adjustment request made by a facility
 149.12 under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months
 149.13 of the completion of the future construction project.

149.14 (n) In subsequent rate years, the property payment rate for a facility that results from
 149.15 the application of this subdivision shall be the amount inflated in subdivision 4.

149.16 (o) Construction projects are eligible for an equity incentive under section 256B.431,
 149.17 subdivision 16. When computing the equity incentive for a construction project under this
 149.18 subdivision, only the allowable costs and allowable debt related to the construction project
 149.19 shall be used. The equity incentive shall not be a part of the property payment rate and not
 149.20 inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing
 149.21 facilities reimbursed under this section shall be allowed for a duration determined under
 149.22 section 256B.431, subdivision 16, paragraph (c).

149.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

149.24 Sec. 25. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

149.25 Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a
 149.26 written notice of appeal; the appeal must be postmarked or received by the commissioner
 149.27 within 60 days of the publication date ~~the determination of the payment rate was mailed or~~
 149.28 ~~personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice
 149.29 of appeal must specify each disputed item; the reason for the dispute; the total dollar amount
 149.30 in dispute for each separate disallowance, allocation, or adjustment of each cost item or part
 149.31 of a cost item; the computation that the provider believes is correct; the authority in statute
 149.32 or rule upon which the provider relies for each disputed item; the name and address of the

150.1 person or firm with whom contacts may be made regarding the appeal; and other information
 150.2 required by the commissioner.

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

150.4 Sec. 26. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
 150.5 to read:

150.6 Subd. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415,
 150.7 subpart 7, a vacant bed in an intermediate care facility for persons with developmental
 150.8 disabilities shall be counted as a reserved bed when determining occupancy rates and
 150.9 eligibility for payment of a therapeutic leave day.

150.10 Sec. 27. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

150.11 Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for
 150.12 administering the overall activities of the nursing home. These costs include salaries and
 150.13 wages of the administrator, assistant administrator, business office employees, security
 150.14 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related
 150.15 to business office functions, licenses, ~~and~~ permits except as provided in the external fixed
 150.16 costs category, employee recognition, travel including meals and lodging, all training except
 150.17 as specified in subdivision 17, voice and data communication or transmission, office supplies,
 150.18 property and liability insurance and other forms of insurance ~~not designated to other areas~~
 150.19 except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal
 150.20 services, accounting services, management or business consultants, data processing,
 150.21 information technology, Web site, central or home office costs, business meetings and
 150.22 seminars, postage, fees for professional organizations, subscriptions, security services,
 150.23 advertising, board of directors fees, working capital interest expense, ~~and~~ bad debts, and
 150.24 bad debt collection fees.

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

150.26 Sec. 28. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

150.27 Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means
 150.28 premium expenses for group coverage ~~and reinsurance~~; actual expenses incurred for
 150.29 self-insured plans, including reinsurance; and employer contributions to employee health
 150.30 reimbursement and health savings accounts. Premium and expense costs and contributions
 150.31 are allowable for (1) all employees and (2) the spouse and dependents of those employees

151.1 who ~~meet the definition of full-time employees under the federal Affordable Care Act,~~
151.2 ~~Public Law 111-148~~ are employed on average at least 30 hours per week.

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

151.4 Sec. 29. Minnesota Statutes 2016, section 256R.07, is amended by adding a subdivision
151.5 to read:

151.6 Subd. 6. **Electronic signature.** For documentation requiring a signature under this
151.7 chapter or section 256B.431 or 256B.434, use of an electronic signature as defined under
151.8 section 325L.02, paragraph (h), is allowed.

151.9 Sec. 30. Minnesota Statutes 2016, section 256R.10, is amended by adding a subdivision
151.10 to read:

151.11 Subd. 7. **Not specified allowed costs.** When the cost category for allowed cost items or
151.12 services is not specified in this chapter or the provider reimbursement manual, the
151.13 commissioner, in consultation with stakeholders, shall determine the cost category for the
151.14 allowed cost item or service.

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

151.16 Sec. 31. **[256R.18] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

151.17 Beginning January 1, 2019, the commissioner shall provide to the house of representatives
151.18 and senate committees with jurisdiction over nursing facility payment rates a biennial report
151.19 on the effectiveness of the reimbursement system in improving quality, restraining costs,
151.20 and any other features of the system as determined by the commissioner.

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

151.22 Sec. 32. Minnesota Statutes 2016, section 256R.37, is amended to read:

151.23 **256R.37 SCHOLARSHIPS.**

151.24 (a) For the 27-month period beginning October 1, 2015, through December 31, 2017,
151.25 the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing
151.26 facility with no scholarship per diem that is requesting a scholarship per diem to be added
151.27 to the external fixed payment rate to be used:

151.28 (1) for employee scholarships that satisfy the following requirements:

152.1 (i) scholarships are available to all employees who work an average of at least ten hours
152.2 per week at the facility except the administrator, and to reimburse student loan expenses
152.3 for newly hired ~~and recently graduated~~ registered nurses and licensed practical nurses, and
152.4 training expenses for nursing assistants as specified in section 144A.611, subdivisions 2
152.5 and 4, who are newly hired ~~and have graduated within the last 12 months~~; and

152.6 (ii) the course of study is expected to lead to career advancement with the facility or in
152.7 long-term care, including medical care interpreter services and social work; and

152.8 (2) to provide job-related training in English as a second language.

152.9 (b) All facilities may annually request a rate adjustment under this section by submitting
152.10 information to the commissioner on a schedule and in a form supplied by the commissioner.
152.11 The commissioner shall allow a scholarship payment rate equal to the reported and allowable
152.12 costs divided by resident days.

152.13 (c) In calculating the per diem under paragraph (b), the commissioner shall allow costs
152.14 related to tuition, direct educational expenses, and reasonable costs as defined by the
152.15 commissioner for child care costs and transportation expenses related to direct educational
152.16 expenses.

152.17 (d) The rate increase under this section is an optional rate add-on that the facility must
152.18 request from the commissioner in a manner prescribed by the commissioner. The rate
152.19 increase must be used for scholarships as specified in this section.

152.20 (e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities
152.21 that close beds during a rate year may request to have their scholarship adjustment under
152.22 paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect
152.23 the reduction in resident days compared to the cost report year.

152.24 Sec. 33. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

152.25 Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the
152.26 amount of the planned closure rate adjustment available under subdivision 6 according to
152.27 clauses (1) to (4):

152.28 (1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

152.29 (2) the total number of beds in the nursing facility or facilities receiving the planned
152.30 closure rate adjustment must be identified;

152.31 (3) capacity days are determined by multiplying the number determined under clause
152.32 (2) by 365; and

153.1 (4) the planned closure rate adjustment is the amount available in clause (1), divided by
 153.2 capacity days determined under clause (3).

153.3 (b) A planned closure rate adjustment under this section is effective on the first day of
 153.4 the month of January or July, whichever occurs immediately following completion of closure
 153.5 of the facility designated for closure in the application and becomes part of the nursing
 153.6 facility's external fixed payment rate.

153.7 (c) Upon the request of a closing facility, the commissioner must allow the facility a
 153.8 closure rate adjustment as provided under section 144A.161, subdivision 10.

153.9 (d) A facility that has received a planned closure rate adjustment may reassign it to
 153.10 another facility that is under the same ownership at any time within three years of its effective
 153.11 date. The amount of the adjustment is computed according to paragraph (a).

153.12 (e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the
 153.13 commissioner shall recalculate planned closure rate adjustments for facilities that delicense
 153.14 beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar
 153.15 amount. The recalculated planned closure rate adjustment is effective from the date the per
 153.16 bed dollar amount is increased.

153.17 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

153.18 Sec. 34. Minnesota Statutes 2016, section 256R.41, is amended to read:

153.19 **256R.41 SINGLE-BED ROOM INCENTIVE.**

153.20 (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed
 153.21 under this chapter shall be increased by 20 percent multiplied by the ratio of the number of
 153.22 new single-bed rooms created divided by the number of active beds on July 1, 2005, for
 153.23 each bed closure that results in the creation of a single-bed room after July 1, 2005. The
 153.24 commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each
 153.25 year. For eligible bed closures for which the commissioner receives a notice from a facility
 153.26 ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has
 153.27 been established, the rate adjustment in this paragraph shall be effective on either the first
 153.28 day of the ~~second~~ month ~~following that calendar quarter~~ of January or July, whichever
 153.29 occurs immediately following the date of the bed delicensure.

153.30 (b) A nursing facility is prohibited from discharging residents for purposes of establishing
 153.31 single-bed rooms. A nursing facility must submit documentation to the commissioner in a
 153.32 form prescribed by the commissioner, certifying the occupancy status of beds closed to
 153.33 create single-bed rooms. In the event that the commissioner determines that a facility has

154.1 discharged a resident for purposes of establishing a single-bed room, the commissioner shall
 154.2 not provide a rate adjustment under paragraph (a).

154.3 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

154.4 Sec. 35. Minnesota Statutes 2016, section 256R.47, is amended to read:

154.5 **256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING**
 154.6 **FACILITIES.**

154.7 (a) The commissioner, in consultation with the commissioner of health, may designate
 154.8 certain nursing facilities as critical access nursing facilities. The designation shall be granted
 154.9 on a competitive basis, within the limits of funds appropriated for this purpose.

154.10 (b) The commissioner shall request proposals from nursing facilities every two years.
 154.11 Proposals must be submitted in the form and according to the timelines established by the
 154.12 commissioner. In selecting applicants to designate, the commissioner, in consultation with
 154.13 the commissioner of health, and with input from stakeholders, shall develop criteria designed
 154.14 to preserve access to nursing facility services in isolated areas, rebalance long-term care,
 154.15 and improve quality. To the extent practicable, the commissioner shall ensure an even
 154.16 distribution of designations across the state.

154.17 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities
 154.18 designated as critical access nursing facilities:

154.19 (1) partial rebasing, with the commissioner allowing a designated facility operating
 154.20 payment rates being the sum of up to 60 percent of the operating payment rate determined
 154.21 in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of
 154.22 the two portions being equal to 100 percent, of the operating payment rate that would have
 154.23 been allowed had the facility not been designated. The commissioner may adjust these
 154.24 percentages by up to 20 percent and may approve a request for less than the amount allowed;

154.25 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
 154.26 designation as a critical access nursing facility, the commissioner shall limit payment for
 154.27 leave days to 60 percent of that nursing facility's total payment rate for the involved resident,
 154.28 and shall allow this payment only when the occupancy of the nursing facility, inclusive of
 154.29 bed hold days, is equal to or greater than 90 percent;

154.30 (3) two designated critical access nursing facilities, with up to 100 beds in active service,
 154.31 may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part
 154.32 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner

155.1 of health shall consider each waiver request independently based on the criteria under
 155.2 Minnesota Rules, part 4658.0040;

155.3 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall
 155.4 be 40 percent of the amount that would otherwise apply; and

155.5 (5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to
 155.6 designated critical access nursing facilities.

155.7 (d) Designation of a critical access nursing facility is for a period of two years, after
 155.8 which the benefits allowed under paragraph (c) shall be removed. Designated facilities may
 155.9 apply for continued designation.

155.10 (e) This section is suspended and no state or federal funding shall be appropriated or
 155.11 allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

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

155.13 Sec. 36. Minnesota Statutes 2016, section 256R.49, subdivision 1, is amended to read:

155.14 Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating payment~~
 155.15 ~~rates of all nursing facilities that are reimbursed under this chapter shall be increased effective~~
 155.16 ~~for rate years beginning on and after October 1, 2014, to address changes in compensation~~
 155.17 ~~costs for nursing facility employees paid less than \$14 per hour in accordance with this~~
 155.18 ~~section.~~ Rate increases provided under this section before October 1, 2016, expire effective
 155.19 January 1, 2018, and rate increases provided on or after October 1, 2016, expire effective
 155.20 January 1, 2019.

155.21 (b) Nursing facilities that receive approval of the applications in subdivision 2 must
 155.22 receive rate adjustments according to subdivision 4. The rate adjustments must be used to
 155.23 pay compensation costs for nursing facility employees paid less than \$14 per hour.

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

155.25 Sec. 37. **DIRECTION TO COMMISSIONER; ADULT DAY SERVICES STAFFING**
 155.26 **RATIOS.**

155.27 The commissioner of human services shall study the staffing ratio for adult day services
 155.28 clients and shall provide the chairs and ranking minority members of the house of
 155.29 representatives and senate committees with jurisdiction over adult day services with
 155.30 recommendations to adjust staffing ratios based on client needs by January 1, 2018.

156.1 Sec. 38. **REVISOR'S INSTRUCTION.**

156.2 The revisor of statutes, in consultation with the House Research Department, Office of
156.3 Senate Counsel, Research, and Fiscal Analysis, and Department of Human Services shall
156.4 prepare legislation for the 2018 legislative session to recodify laws governing the elderly
156.5 waiver program in Minnesota Statutes, chapter 256B.

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

156.7 **ARTICLE 4**156.8 **HEALTH CARE**

156.9 Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision
156.10 to read:

156.11 **Subd. 2b. Audits of managed care organizations.** (a) The legislative auditor shall audit
156.12 each managed care organization that contracts with the commissioner of human services to
156.13 provide health care services under sections 256B.69, 256B.692, and 256L.12. The legislative
156.14 auditor shall design the audits to determine if a managed care organization used the public
156.15 money in compliance with federal and state laws, rules, and in accordance with provisions
156.16 in the managed care organization's contract with the commissioner of human services. The
156.17 legislative auditor shall determine the schedule and scope of the audit work and may contract
156.18 with vendors to assist with the audits. The managed care organization must cooperate with
156.19 the legislative auditor and must provide the legislative auditor with all data, documents, and
156.20 other information, regardless of classification, that the legislative auditor requests to conduct
156.21 an audit. The legislative auditor shall periodically report audit results and recommendations
156.22 to the Legislative Audit Commission and the chairs and ranking minority members of the
156.23 legislative committees with jurisdiction over health and human services policy and finance.

156.24 (b) For purposes of this subdivision, a "managed care organization" means a
156.25 demonstration provider as defined under section 256B.69, subdivision 2.

156.26 Sec. 2. Minnesota Statutes 2016, section 13.69, subdivision 1, is amended to read:

156.27 Subdivision 1. **Classifications.** (a) The following government data of the Department
156.28 of Public Safety are private data:

156.29 (1) medical data on driving instructors, licensed drivers, and applicants for parking
156.30 certificates and special license plates issued to physically disabled persons;

156.31 (2) other data on holders of a disability certificate under section 169.345, except that (i)
156.32 data that are not medical data may be released to law enforcement agencies, and (ii) data

157.1 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
 157.2 enforcement employees or parking enforcement agents of statutory or home rule charter
 157.3 cities and towns;

157.4 (3) Social Security numbers in driver's license and motor vehicle registration records,
 157.5 except that Social Security numbers must be provided to the Department of Revenue for
 157.6 purposes of tax administration, the Department of Labor and Industry for purposes of
 157.7 workers' compensation administration and enforcement, the Department of Human Services
 157.8 for purposes of recovery of Minnesota health care program benefits paid, and the Department
 157.9 of Natural Resources for purposes of license application administration; and

157.10 (4) data on persons listed as standby or temporary custodians under section 171.07,
 157.11 subdivision 11, except that the data must be released to:

157.12 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
 157.13 caregiver; or

157.14 (ii) law enforcement agencies who state that the license holder is unable to communicate
 157.15 at that time and that the information is necessary for notifying the designated caregiver of
 157.16 the need to care for a child of the license holder.

157.17 The department may release the Social Security number only as provided in clause (3)
 157.18 and must not sell or otherwise provide individual Social Security numbers or lists of Social
 157.19 Security numbers for any other purpose.

157.20 (b) The following government data of the Department of Public Safety are confidential
 157.21 data: data concerning an individual's driving ability when that data is received from a member
 157.22 of the individual's family.

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

157.24 Sec. 3. Minnesota Statutes 2016, section 62U.02, is amended to read:

157.25 **62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.**

157.26 Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized
 157.27 set of measures for use by health plan companies as specified in subdivision 5. As part of
 157.28 the standardized set of measures, the commissioner shall establish statewide measures by
 157.29 which to assess the quality of health care services offered by health care providers, including
 157.30 health care providers certified as health care homes under section 256B.0751. ~~Quality~~
 157.31 ~~measures must be based on medical evidence and be developed through a process in which~~
 157.32 ~~providers participate.~~ The statewide measures shall be used for the quality incentive payment

158.1 system developed in subdivision 2 and the quality transparency requirements in subdivision
158.2 3. The statewide measures must:

158.3 (1) for purposes of assessing the quality of care provided at physician clinics, including
158.4 clinics certified as health care homes under section 256B.0751, be selected from the available
158.5 measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended,
158.6 unless the stakeholders identified under paragraph (b) determine that a particular diagnosis,
158.7 condition, service, or procedure is not reflected in any of the available measures in a way
158.8 that meets identified needs;

158.9 (2) be based on medical evidence;

158.10 (3) be developed through a process in which providers participate and consumer and
158.11 community input and perspectives are obtained;

158.12 ~~(4)~~ (4) include uniform definitions, measures, and forms for submission of data, to the
158.13 greatest extent possible;

158.14 ~~(2)~~ (5) seek to avoid increasing the administrative burden on health care providers; and

158.15 ~~(3) be initially based on existing quality indicators for physician and hospital services,~~
158.16 ~~which are measured and reported publicly by quality measurement organizations, including,~~
158.17 ~~but not limited to, Minnesota Community Measurement and specialty societies;~~

158.18 ~~(4)~~ (6) place a priority on measures of health care outcomes, rather than process measures,
158.19 wherever possible; and

158.20 ~~(5) incorporate measures for primary care, including preventive services, coronary artery~~
158.21 ~~and heart disease, diabetes, asthma, depression, and other measures as determined by the~~
158.22 ~~commissioner.~~

158.23 The measures may also include measures of care infrastructure and patient satisfaction.

158.24 (b) By June 30, 2018, the commissioner shall develop a measurement framework that
158.25 identifies the most important elements for assessing the quality of care, articulates statewide
158.26 quality improvement goals, ensures clinical relevance, fosters alignment with other
158.27 measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the
158.28 commissioner shall use the framework to update the statewide measures used to assess the
158.29 quality of health care services offered by health care providers, including health care
158.30 providers certified as health care homes under section 256B.0751. No more than six statewide
158.31 measures shall be required for single-specialty physician practices and no more than ten
158.32 statewide measures shall be required for multispecialty physician practices. Measures in
158.33 addition to the six statewide measures for single-specialty practices and the ten statewide

159.1 measures for multispecialty practices may be included for a physician practice if derived
159.2 from administrative claims data. Care infrastructure measures collected according to section
159.3 62J.495 shall not be counted toward the maximum number of measures specified in this
159.4 paragraph. The commissioner shall develop the framework in consultation with stakeholders
159.5 that include consumer, community, and advocacy organizations representing diverse
159.6 communities and patients; health plan companies; health care providers whose quality is
159.7 assessed, including providers who serve primarily socioeconomically complex patient
159.8 populations; health care purchasers; community health boards; and quality improvement
159.9 and measurement organizations. The commissioner, in consultation with stakeholders, shall
159.10 review the framework at least once every three years. The commissioner shall also submit
159.11 a report to the chairs and ranking minority members of the legislative committees with
159.12 jurisdiction over health and human services policy and finance by September 30, 2018,
159.13 summarizing the development of the measurement framework and making recommendations
159.14 on the type and appropriate maximum number of measures in the statewide measures set
159.15 for implementation on January 1, 2020.

159.16 ~~(b)~~ (c) Effective July 1, 2016, the commissioner shall stratify quality measures by race,
159.17 ethnicity, preferred language, and country of origin beginning with five measures, and
159.18 stratifying additional measures to the extent resources are available. On or after January 1,
159.19 2018, the commissioner may require measures to be stratified by other sociodemographic
159.20 factors or composite indices of multiple factors that according to reliable data are correlated
159.21 with health disparities and have an impact on performance on quality or cost indicators.
159.22 New methods of stratifying data under this paragraph must be tested and evaluated through
159.23 pilot projects prior to adding them to the statewide system. In determining whether to add
159.24 additional sociodemographic factors and developing the methodology to be used, the
159.25 commissioner shall consider the reporting burden on providers and determine whether there
159.26 are alternative sources of data that could be used. The commissioner shall ensure that
159.27 categories and data collection methods are developed in consultation with those communities
159.28 impacted by health disparities using culturally appropriate community engagement principles
159.29 and methods. The commissioner shall implement this paragraph in coordination with the
159.30 contracting entity retained under subdivision 4, in order to build upon the data stratification
159.31 methodology that has been developed and tested by the entity. Nothing in this paragraph
159.32 expands or changes the commissioner's authority to collect, analyze, or report health care
159.33 data. Any data collected to implement this paragraph must be data that is available or is
159.34 authorized to be collected under other laws. Nothing in this paragraph grants authority to
159.35 the commissioner to collect or analyze patient-level or patient-specific data of the patient
159.36 characteristics identified under this paragraph.

160.1 ~~(e)~~ (d) The statewide measures shall be reviewed at least annually by the commissioner.

160.2 Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall
 160.3 develop a system of quality incentive payments under which providers are eligible for
 160.4 quality-based payments that are in addition to existing payment levels, based upon a
 160.5 comparison of provider performance against specified targets, and improvement over time.
 160.6 The targets must be based upon and consistent with the quality measures established under
 160.7 subdivision 1.

160.8 (b) To the extent possible, the payment system must adjust for variations in patient
 160.9 population in order to reduce incentives to health care providers to avoid high-risk patients
 160.10 or populations, including those with risk factors related to race, ethnicity, language, country
 160.11 of origin, and sociodemographic factors.

160.12 (c) The requirements of section 62Q.101 do not apply under this incentive payment
 160.13 system.

160.14 Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for
 160.15 measuring health outcomes, establish a system for risk adjusting quality measures, and issue
 160.16 ~~annual~~ periodic public reports on trends in provider quality beginning July 1, 2010 at the
 160.17 statewide, regional, or clinic levels.

160.18 (b) Effective July 1, 2017, the risk adjustment system established under this subdivision
 160.19 shall adjust for patient characteristics identified under subdivision 1, paragraph ~~(b)~~ (c), that
 160.20 are correlated with health disparities and have an impact on performance on cost and quality
 160.21 measures. The risk adjustment method may consist of reporting based on an
 160.22 actual-to-expected comparison that reflects the characteristics of the patient population
 160.23 served by the clinic or hospital. The commissioner shall implement this paragraph in
 160.24 coordination with any contracting entity retained under subdivision 4.

160.25 (c) ~~By January 1, 2010,~~ Physician clinics and hospitals shall submit standardized
 160.26 ~~electronic information on the outcomes and processes associated with patient care~~ for the
 160.27 identified statewide measures to the commissioner or the commissioner's designee in the
 160.28 formats specified by the commissioner, which must include alternative formats for clinics
 160.29 or hospitals experiencing technological or economic barriers to submission in standardized
 160.30 electronic form. ~~In addition to measures of care processes and outcomes, the report may~~
 160.31 ~~include other measures designated by the commissioner, including, but not limited to, care~~
 160.32 ~~infrastructure and patient satisfaction. The commissioner shall ensure that any quality data~~
 160.33 ~~reporting requirements established under this subdivision are not duplicative of publicly~~
 160.34 ~~reported, communitywide quality reporting activities currently under way in Minnesota.~~

161.1 The commissioner shall ensure that any quality data reporting requirements for physician
 161.2 clinics are aligned with the specifications and timelines for the selected measures as defined
 161.3 in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional data
 161.4 on race, ethnicity, preferred language, country of origin, or other sociodemographic factors
 161.5 as identified under subdivision 1, paragraph (c), and as required for stratification or risk
 161.6 adjustment. None of the statewide measures selected shall require providers to use an external
 161.7 vendor to administer or collect data. ~~Nothing in this subdivision is intended to replace or~~
 161.8 ~~duplicate current privately supported activities related to quality measurement and reporting~~
 161.9 ~~in Minnesota.~~

161.10 Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium
 161.11 of private entities to complete the tasks in subdivisions 1 to 3. The private entity or
 161.12 consortium must be nonprofit and have governance that includes representatives from the
 161.13 following stakeholder groups: health care providers, including providers serving high
 161.14 concentrations of patients and communities impacted by health disparities; health plan
 161.15 companies; consumers, including consumers representing groups who experience health
 161.16 disparities; employers or other health care purchasers; and state government. No one
 161.17 stakeholder group shall have a majority of the votes on any issue or hold extraordinary
 161.18 powers not granted to any other governance stakeholder.

161.19 Subd. 5. **Implementation.** ~~(a) By January 1, 2010,~~ Health plan companies shall use the
 161.20 standardized quality set of measures established under this section and shall not require
 161.21 providers to use and report health plan company-specific quality and outcome measures.

161.22 ~~(b) By July 1, 2010, the commissioner of management and budget shall implement this~~
 161.23 ~~incentive payment system for all participants in the state employee group insurance program.~~

161.24 Sec. 4. Minnesota Statutes 2016, section 62V.05, subdivision 12, is amended to read:

161.25 Subd. 12. **Reports on interagency agreements and intra-agency transfers.** The
 161.26 MNsure Board shall provide quarterly reports to the chairs and ranking minority members
 161.27 of the legislative committees with jurisdiction over health and human services policy and
 161.28 finance on:

161.29 (1) interagency agreements or service-level agreements and any renewals or extensions
 161.30 of existing interagency or service-level agreements with a state department under section
 161.31 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of
 161.32 more than \$100,000, or related agreements with the same department or agency with a
 161.33 cumulative value of more than \$100,000; and

162.1 (2) transfers of appropriations of more than \$100,000 between accounts within or between
162.2 agencies.

162.3 The report must include the statutory citation authorizing the agreement, transfer or dollar
162.4 amount, purpose, and effective date of the agreement, and the duration of the agreement,
162.5 ~~and a copy of the agreement.~~

162.6 Sec. 5. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to
162.7 read:

162.8 Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset
162.9 Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to
162.10 verify assets for an individual applying for or renewing health care benefits under section
162.11 256B.055, subdivision 7.

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

162.13 Sec. 6. Minnesota Statutes 2016, section 256.01, subdivision 41, is amended to read:

162.14 Subd. 41. **Reports on interagency agreements and intra-agency transfers.** The
162.15 commissioner of human services shall provide quarterly reports to the chairs and ranking
162.16 minority members of the legislative committees with jurisdiction over health and human
162.17 services policy and finance on:

162.18 (1) interagency agreements or service-level agreements and any renewals or extensions
162.19 of existing interagency or service-level agreements with a state department under section
162.20 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of
162.21 more than \$100,000, or related agreements with the same department or agency with a
162.22 cumulative value of more than \$100,000; and

162.23 (2) transfers of appropriations of more than \$100,000 between accounts within or between
162.24 agencies.

162.25 The report must include the statutory citation authorizing the agreement, transfer or dollar
162.26 amount, purpose, and effective date of the agreement, and the duration of the agreement,
162.27 ~~and a copy of the agreement.~~

162.28 Sec. 7. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

162.29 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
162.30 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
162.31 to the following:

163.1 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
163.2 methodology;

163.3 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
163.4 under subdivision 25;

163.5 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
163.6 distinct parts as defined by Medicare shall be paid according to the methodology under
163.7 subdivision 12; and

163.8 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

163.9 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
163.10 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
163.11 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
163.12 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
163.13 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
163.14 years are updated, a Minnesota long-term hospital's base year shall remain within the same
163.15 period as other hospitals.

163.16 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
163.17 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
163.18 area, except for the hospitals paid under the methodologies described in paragraph (a),
163.19 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
163.20 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
163.21 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
163.22 that the total aggregate payments under the rebased system are equal to the total aggregate
163.23 payments that were made for the same number and types of services in the base year. Separate
163.24 budget neutrality calculations shall be determined for payments made to critical access
163.25 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases
163.26 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during
163.27 the entire base period shall be incorporated into the budget neutrality calculation.

163.28 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
163.29 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
163.30 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
163.31 a five percent increase or decrease from the base year payments for any hospital. Any
163.32 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
163.33 shall maintain budget neutrality as described in paragraph (c).

164.1 (e) For discharges occurring on or after November 1, 2014, through the next rebasing
164.2 that occurs the commissioner may make additional adjustments to the rebased rates, and
164.3 when evaluating whether additional adjustments should be made, the commissioner shall
164.4 consider the impact of the rates on the following:

164.5 (1) pediatric services;

164.6 (2) behavioral health services;

164.7 (3) trauma services as defined by the National Uniform Billing Committee;

164.8 (4) transplant services;

164.9 (5) obstetric services, newborn services, and behavioral health services provided by
164.10 hospitals outside the seven-county metropolitan area;

164.11 (6) outlier admissions;

164.12 (7) low-volume providers; and

164.13 (8) services provided by small rural hospitals that are not critical access hospitals.

164.14 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

164.15 (1) for hospitals paid under the DRG methodology, the base year payment rate per
164.16 admission is standardized by the applicable Medicare wage index and adjusted by the
164.17 hospital's disproportionate population adjustment;

164.18 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
164.19 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
164.20 October 31, 2014;

164.21 (3) the cost and charge data used to establish hospital payment rates must only reflect
164.22 inpatient services covered by medical assistance; and

164.23 (4) in determining hospital payment rates for discharges occurring on or after the rate
164.24 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
164.25 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
164.26 program in effect during the base year or years.

164.27 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
164.28 the rates established under paragraph (c), and any adjustments made to the rates under
164.29 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
164.30 total aggregate payments for the same number and types of services under the rebased rates
164.31 are equal to the total aggregate payments made during calendar year 2013.

165.1 (h) Effective for discharges occurring on or after July 1, ~~2017~~ 2021, and every two years
165.2 thereafter, payment rates under this section shall be rebased to reflect only those changes
165.3 in hospital costs between the existing base year and the next base year. The commissioner
165.4 shall establish the base year for each rebasing period considering the most recent year for
165.5 which filed Medicare cost reports are available. The estimated change in the average payment
165.6 per hospital discharge resulting from a scheduled rebasing must be calculated and made
165.7 available to the legislature by January 15 of each year in which rebasing is scheduled to
165.8 occur, and must include by hospital the differential in payment rates compared to the
165.9 individual hospital's costs.

165.10 (i) Effective for discharges occurring on or after July 1, 2015, payment rates for critical
165.11 access hospitals located in Minnesota or the local trade area shall be determined using a
165.12 new cost-based methodology. The commissioner shall establish within the methodology
165.13 tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for
165.14 hospitals under this paragraph shall be set at a level that does not exceed the total cost for
165.15 critical access hospitals as reflected in base year cost reports. Until the next rebasing that
165.16 occurs, the new methodology shall result in no greater than a five percent decrease from
165.17 the base year payments for any hospital, except a hospital that had payments that were
165.18 greater than 100 percent of the hospital's costs in the base year shall have their rate set equal
165.19 to 100 percent of costs in the base year. The rates paid for discharges on and after July 1,
165.20 2016, covered under this paragraph shall be increased by the inflation factor in subdivision
165.21 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to
165.22 actual incurred costs. Hospitals shall be assigned a payment tier based on the following
165.23 criteria:

165.24 (1) hospitals that had payments at or below 80 percent of their costs in the base year
165.25 shall have a rate set that equals 85 percent of their base year costs;

165.26 (2) hospitals that had payments that were above 80 percent, up to and including 90
165.27 percent of their costs in the base year shall have a rate set that equals 95 percent of their
165.28 base year costs; and

165.29 (3) hospitals that had payments that were above 90 percent of their costs in the base year
165.30 shall have a rate set that equals 100 percent of their base year costs.

165.31 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
165.32 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
165.33 methodology may include, but are not limited to:

166.1 (1) the ratio between the hospital's costs for treating medical assistance patients and the
166.2 hospital's charges to the medical assistance program;

166.3 (2) the ratio between the hospital's costs for treating medical assistance patients and the
166.4 hospital's payments received from the medical assistance program for the care of medical
166.5 assistance patients;

166.6 (3) the ratio between the hospital's charges to the medical assistance program and the
166.7 hospital's payments received from the medical assistance program for the care of medical
166.8 assistance patients;

166.9 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

166.10 (5) the proportion of that hospital's costs that are administrative and trends in
166.11 administrative costs; and

166.12 (6) geographic location.

166.13 Sec. 8. Minnesota Statutes 2016, section 256.969, is amended by adding a subdivision to
166.14 read:

166.15 Subd. 2e. **Alternate inpatient payment rate.** (a) If the days, costs, and revenues
166.16 associated with patients who are eligible for medical assistance and also have private health
166.17 insurance are required to be included in the calculation of the hospital-specific
166.18 disproportionate share hospital payment limit for a rate year, then the commissioner, effective
166.19 retroactively from rate years beginning on or after January 1, 2015, shall compute an alternate
166.20 inpatient payment rate for a Minnesota hospital that is designated as a children's hospital
166.21 and enumerated as such by Medicare. The commissioner shall reimburse the hospital for a
166.22 rate year at the higher of the amount calculated under the alternate payment rate or the
166.23 amount calculated under subdivision 9.

166.24 (b) The alternate payment rate must meet the criteria in clauses (1) to (4):

166.25 (1) the alternate payment rate shall be structured to target a total aggregate reimbursement
166.26 amount equal to two percent less than each children's hospital's cost coverage percentage
166.27 in the applicable base year for providing fee-for-service inpatient services under this section
166.28 to patients enrolled in medical assistance;

166.29 (2) costs shall be determined using the most recently available medical assistance cost
166.30 report provided under subdivision 4b, paragraph (a), clause (3), for the applicable base year.
166.31 Costs shall be determined using standard Medicare cost finding and cost allocation methods
166.32 and applied in the same manner as the costs were in the rebasing for the applicable base

167.1 year. If the medical assistance cost report is not available, costs shall be determined in the
167.2 interim using the Medicare cost report;

167.3 (3) in any rate year in which payment to a hospital is made using the alternate payment
167.4 rate, no payments shall be made to the hospital under subdivision 9; and

167.5 (4) if the alternate payment amount increases payments at a rate that is higher than the
167.6 inflation factor applied over the rebasing period, the commissioner shall take this into
167.7 consideration when setting payment rates at the next rebasing.

167.8 Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

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

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

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

167.16 (3) a Minnesota hospital that is designated as a children's hospital and enumerated as
167.17 such by Medicare.

167.18 For purposes of this subdivision, local trade area has the meaning given in subdivision
167.19 17.

167.20 (b) The commissioner shall suspend payments to any hospital that fails to submit a report
167.21 required under this subdivision. Payments must remain suspended until the report has been
167.22 filed with and accepted by the commissioner.

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

167.24 Sec. 10. **[256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

167.25 Subdivision 1. **Contract for dental administration services.** (a) The commissioner
167.26 shall contract with up to two dental administrators to administer dental services for all
167.27 recipients of medical assistance and MinnesotaCare except for those recipients enrolled in
167.28 a county-based purchasing plan. The commissioner shall contract with a county-based
167.29 purchasing plan to receive payment for dental services on a prospective per capita basis or
167.30 through an alternative mutually agreed-to arrangement.

168.1 (b) The dental administrator must provide administrative services, including, but not
168.2 limited to:

168.3 (1) provider recruitment, contracting, and assistance;

168.4 (2) recipient outreach and assistance;

168.5 (3) utilization management and review for medical necessity of dental services;

168.6 (4) dental claims processing, including submission of encounter claims to the department;

168.7 (5) coordination with other services;

168.8 (6) management of fraud and abuse;

168.9 (7) monitoring of access to dental services;

168.10 (8) performance measurement;

168.11 (9) quality improvement and evaluation requirements; and

168.12 (10) management of third party liability requirements.

168.13 (c) A payment to a contracted dental provider shall be at the rates established under
168.14 section 256B.76.

168.15 Subd. 2. **Requirements.** (a) Recipients shall be given a choice of dental provider,
168.16 including any provider who agrees to the provider participation requirements and payment
168.17 rates established under this section. The commissioner and dental services administrator
168.18 shall comply with the network adequacy, geographic access, and essential community
168.19 provider requirements that apply to health plans and county-based purchasing organizations
168.20 for nondental services.

168.21 (b) The commissioner shall implement this section in consultation with representatives
168.22 of providers who provide dental services to patients enrolled in medical assistance or
168.23 MinnesotaCare, including, but not limited to, providers who serve primarily low-income
168.24 and socioeconomically complex patient populations.

168.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

168.26 Sec. 11. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

168.27 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct
168.28 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
168.29 E, including database checks, unannounced pre- and post-enrollment site visits, fingerprinting,
168.30 and criminal background studies. A provider providing services from multiple locations

169.1 must enroll each location separately. The commissioner may deny a provider's incomplete
169.2 application for enrollment if a provider fails to respond to the commissioner's request for
169.3 additional information within 60 days of the request.

169.4 (b) The commissioner must revalidate each provider under this subdivision at least once
169.5 every five years. The commissioner may revalidate a personal care assistance agency under
169.6 this subdivision once every three years. The commissioner shall conduct revalidation as
169.7 follows:

169.8 (1) provide 30-day notice of revalidation due date to include instructions for revalidation
169.9 and a list of materials the provider must submit to revalidate;

169.10 (2) notify the provider that fails to completely respond within 30 days of any deficiencies
169.11 and allow an additional 30 days to comply; and

169.12 (3) give 60-day notice of termination and immediately suspend a provider's ability to
169.13 bill for failure to remedy any deficiencies within the 30-day time period. The provider shall
169.14 have no right to appeal suspension of ability to bill.

169.15 (c) The commissioner may suspend a provider's ability to bill for a failure to comply
169.16 with any individual provider requirements or conditions of participation until the provider
169.17 comes into compliance. The commissioner's decision to suspend the provider is not subject
169.18 to an administrative appeal.

169.19 (d) Notwithstanding any other provision to the contrary, all correspondence and
169.20 notifications, including notifications of termination and other actions, shall be delivered
169.21 electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS
169.22 account and mailbox, notice shall be sent by first class mail.

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

169.27 ~~(b)~~ (f) An enrolled provider that is also licensed by the commissioner under chapter
169.28 245A, or is licensed as a home care provider by the Department of Health under chapter
169.29 144A and has a home and community-based services designation on the home care license
169.30 under section 144A.484, must designate an individual as the entity's compliance officer.
169.31 The compliance officer must:

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

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

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

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

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

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

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

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

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

170.27 ~~(e)~~ (i) As a condition of enrollment in medical assistance, the commissioner shall require
170.28 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
170.29 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
170.30 Services, its agents, or its designated contractors and the state agency, its agents, or its
170.31 designated contractors to conduct unannounced on-site inspections of any provider location.
170.32 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
170.33 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria

171.1 and standards used to designate Medicare providers in Code of Federal Regulations, title
171.2 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
171.3 The commissioner's designations are not subject to administrative appeal.

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

171.10 ~~(g)~~ (k)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all
171.11 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
171.12 meeting the durable medical equipment provider and supplier definition in clause (3),
171.13 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
171.14 annually renewed and designates the Minnesota Department of Human Services as the
171.15 obligee, and must be submitted in a form approved by the commissioner. For purposes of
171.16 this clause, the following medical suppliers are not required to obtain a surety bond: a
171.17 federally qualified health center, a home health agency, the Indian Health Service, a
171.18 pharmacy, and a rural health clinic.

171.19 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
171.20 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
171.21 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
171.22 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
171.23 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
171.24 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
171.25 fees in pursuing a claim on the bond.

171.26 (3) "Durable medical equipment provider or supplier" means a medical supplier that can
171.27 purchase medical equipment or supplies for sale or rental to the general public and is able
171.28 to perform or arrange for necessary repairs to and maintenance of equipment offered for
171.29 sale or rental.

171.30 ~~(h)~~ (l) The Department of Human Services may require a provider to purchase a surety
171.31 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment
171.32 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
171.33 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
171.34 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (e) and

172.1 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in
 172.2 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
 172.3 immediately preceding 12 months, whichever is greater. The surety bond must name the
 172.4 Department of Human Services as an obligee and must allow for recovery of costs and fees
 172.5 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
 172.6 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

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

172.8 Sec. 12. Minnesota Statutes 2016, section 256B.04, subdivision 22, is amended to read:

172.9 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
 172.10 required nonrefundable application fees to pay for provider screening activities in accordance
 172.11 with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application
 172.12 must be made under the procedures specified by the commissioner, in the form specified
 172.13 by the commissioner, and accompanied by an application fee described in paragraph (b),
 172.14 or a request for a hardship exception as described in the specified procedures. Application
 172.15 fees must be deposited in the provider screening account in the special revenue fund.
 172.16 Amounts in the provider screening account are appropriated to the commissioner for costs
 172.17 associated with the provider screening activities required in Code of Federal Regulations,
 172.18 title 42, section 455, subpart E. The commissioner ~~shall conduct screening activities as~~
 172.19 ~~required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise~~
 172.20 ~~provided by law, to include database checks, unannounced pre- and postenrollment site~~
 172.21 ~~visits, fingerprinting, and criminal background studies. The commissioner must revalidate~~
 172.22 ~~all providers under this subdivision at least once every five years~~ must revalidate all personal
 172.23 care assistance agencies under this subdivision at least once every three years.

172.24 (b) The application fee under this subdivision is \$532 for the calendar year 2013. For
 172.25 calendar year 2014 and subsequent years, the fee:

172.26 (1) is adjusted by the percentage change to the Consumer Price Index for all urban
 172.27 consumers, United States city average, for the 12-month period ending with June of the
 172.28 previous year. The resulting fee must be announced in the Federal Register;

172.29 (2) is effective from January 1 to December 31 of a calendar year;

172.30 (3) is required on the submission of an initial application, an application to establish a
 172.31 new practice location, an application for reenrollment when the provider is not enrolled at
 172.32 the time of application of reenrollment, or at revalidation when required by federal regulation;
 172.33 and

173.1 (4) must be in the amount in effect for the calendar year during which the application
173.2 for enrollment, new practice location, or reenrollment is being submitted.

173.3 (c) The application fee under this subdivision cannot be charged to:

173.4 (1) providers who are enrolled in Medicare or who provide documentation of payment
173.5 of the fee to, and enrollment with, another state, unless the commissioner is required to
173.6 rescreen the provider;

173.7 (2) providers who are enrolled but are required to submit new applications for purposes
173.8 of reenrollment;

173.9 (3) a provider who enrolls as an individual; and

173.10 (4) group practices and clinics that bill on behalf of individually enrolled providers
173.11 within the practice who have reassigned their billing privileges to the group practice or
173.12 clinic.

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

173.14 Sec. 13. Minnesota Statutes 2016, section 256B.055, subdivision 2, is amended to read:

173.15 Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible
173.16 for or receiving foster care maintenance payments under Title IV-E of the Social Security
173.17 Act, United States Code, title 42, sections 670 to 676, and to any child who is not title IV-E
173.18 eligible but who is determined eligible for foster care or kinship assistance under chapter
173.19 256N.

173.20 **EFFECTIVE DATE.** This section is effective January 1, 2019, or upon federal approval,
173.21 whichever is later. The commissioner of human services shall notify the revisor of statutes
173.22 when federal approval is obtained.

173.23 Sec. 14. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

173.24 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case
173.25 management under this subdivision. Case managers may bill according to the following
173.26 criteria:

173.27 (1) for relocation targeted case management, case managers may bill for direct case
173.28 management activities, including face-to-face ~~and~~ contact, telephone ~~contacts~~ contact, and
173.29 interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

173.30 (i) 180 days preceding an eligible recipient's discharge from an institution; or

174.1 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

174.2 (2) for home care targeted case management, case managers may bill for direct case
174.3 management activities, including face-to-face and telephone contacts; and

174.4 (3) billings for targeted case management services under this subdivision shall not
174.5 duplicate payments made under other program authorities for the same purpose.

174.6 **EFFECTIVE DATE.** This section is effective three months after federal approval.

174.7 Sec. 15. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

174.8 Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in
174.9 a recipient's home. Recipients who are authorized to receive home care nursing services in
174.10 their home may use approved hours outside of the home during hours when normal life
174.11 activities take them outside of their home. To use home care nursing services at school, the
174.12 recipient or responsible party must provide written authorization in the care plan identifying
174.13 the chosen provider and the daily amount of services to be used at school. Medical assistance
174.14 does not cover home care nursing services for residents of a hospital, nursing facility,
174.15 intermediate care facility, or a health care facility licensed by the commissioner of health,
174.16 ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~
174.17 unless a resident who is otherwise eligible is on leave from the facility and the facility either
174.18 pays for the home care nursing services or forgoes the facility per diem for the leave days
174.19 that home care nursing services are used. Total hours of service and payment allowed for
174.20 services outside the home cannot exceed that which is otherwise allowed in an in-home
174.21 setting according to sections 256B.0651 and 256B.0654 . All home care nursing services
174.22 must be provided according to the limits established under sections 256B.0651, 256B.0653,
174.23 and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family
174.24 foster care provider of a recipient who is under age 18, unless allowed under section
174.25 256B.0654, subdivision 4.

174.26 Sec. 16. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

174.27 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
174.28 state agency, medical assistance covers case management services to persons with serious
174.29 and persistent mental illness and children with severe emotional disturbance. Services
174.30 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
174.31 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
174.32 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

175.1 (b) Entities meeting program standards set out in rules governing family community
175.2 support services as defined in section 245.4871, subdivision 17, are eligible for medical
175.3 assistance reimbursement for case management services for children with severe emotional
175.4 disturbance when these services meet the program standards in Minnesota Rules, parts
175.5 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

175.6 (c) Medical assistance and MinnesotaCare payment for mental health case management
175.7 shall be made on a monthly basis. In order to receive payment for an eligible child, the
175.8 provider must document at least a face-to-face contact with the child, the child's parents, or
175.9 the child's legal representative. To receive payment for an eligible adult, the provider must
175.10 document:

175.11 (1) at least a face-to-face contact with the adult or the adult's legal representative or a
175.12 contact by interactive video that meets the requirements of subdivision 20b; or

175.13 (2) at least a telephone contact with the adult or the adult's legal representative and
175.14 document a face-to-face contact or a contact by interactive video that meets the requirements
175.15 of subdivision 20b with the adult or the adult's legal representative within the preceding
175.16 two months.

175.17 (d) Payment for mental health case management provided by county or state staff shall
175.18 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
175.19 (b), with separate rates calculated for child welfare and mental health, and within mental
175.20 health, separate rates for children and adults.

175.21 (e) Payment for mental health case management provided by Indian health services or
175.22 by agencies operated by Indian tribes may be made according to this section or other relevant
175.23 federally approved rate setting methodology.

175.24 (f) Payment for mental health case management provided by vendors who contract with
175.25 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or
175.26 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
175.27 service to other payers. If the service is provided by a team of contracted vendors, the county
175.28 or tribe may negotiate a team rate with a vendor who is a member of the team. The team
175.29 shall determine how to distribute the rate among its members. No reimbursement received
175.30 by contracted vendors shall be returned to the county or tribe, except to reimburse the county
175.31 or tribe for advance funding provided by the county or tribe to the vendor.

175.32 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
175.33 and county or state staff, the costs for county or state staff participation in the team shall be
175.34 included in the rate for county-provided services. In this case, the contracted vendor, the

176.1 tribal agency, and the county may each receive separate payment for services provided by
176.2 each entity in the same month. In order to prevent duplication of services, each entity must
176.3 document, in the recipient's file, the need for team case management and a description of
176.4 the roles of the team members.

176.5 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
176.6 mental health case management shall be provided by the recipient's county of responsibility,
176.7 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
176.8 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
176.9 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
176.10 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
176.11 the recipient's county of responsibility.

176.12 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
176.13 and MinnesotaCare include mental health case management. When the service is provided
176.14 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
176.15 share.

176.16 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
176.17 that does not meet the reporting or other requirements of this section. The county of
176.18 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
176.19 is responsible for any federal disallowances. The county or tribe may share this responsibility
176.20 with its contracted vendors.

176.21 (k) The commissioner shall set aside a portion of the federal funds earned for county
176.22 expenditures under this section to repay the special revenue maximization account under
176.23 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

176.24 (1) the costs of developing and implementing this section; and

176.25 (2) programming the information systems.

176.26 (l) Payments to counties and tribal agencies for case management expenditures under
176.27 this section shall only be made from federal earnings from services provided under this
176.28 section. When this service is paid by the state without a federal share through fee-for-service,
176.29 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
176.30 shall include the federal earnings, the state share, and the county share.

176.31 (m) Case management services under this subdivision do not include therapy, treatment,
176.32 legal, or outreach services.

177.1 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
177.2 and the recipient's institutional care is paid by medical assistance, payment for case
177.3 management services under this subdivision is limited to the lesser of:

177.4 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
177.5 than six months in a calendar year; or

177.6 (2) the limits and conditions which apply to federal Medicaid funding for this service.

177.7 (o) Payment for case management services under this subdivision shall not duplicate
177.8 payments made under other program authorities for the same purpose.

177.9 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
177.10 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
177.11 mental health targeted case management services must actively support identification of
177.12 community alternatives for the recipient and discharge planning.

177.13 **EFFECTIVE DATE.** This section is effective three months after federal approval.

177.14 Sec. 17. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
177.15 to read:

177.16 **Subd. 20b. Mental health targeted case management through interactive video.** (a)
177.17 Subject to federal approval, contact made for targeted case management by interactive video
177.18 shall be eligible for payment if:

177.19 (1) the person receiving targeted case management services is residing in:

177.20 (i) a hospital;

177.21 (ii) a nursing facility; or

177.22 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
177.23 establishment or lodging establishment that provides supportive services or health supervision
177.24 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

177.25 (2) interactive video is in the best interests of the person and is deemed appropriate by
177.26 the person receiving targeted case management or the person's legal guardian, the case
177.27 management provider, and the provider operating the setting where the person is residing;

177.28 (3) the use of interactive video is approved as part of the person's written personal service
177.29 or case plan, taking into consideration the person's vulnerability and active personal
177.30 relationships; and

178.1 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
178.2 required face-to-face contact.

178.3 (b) The person receiving targeted case management or the person's legal guardian has
178.4 the right to choose and consent to the use of interactive video under this subdivision and
178.5 has the right to refuse the use of interactive video at any time.

178.6 (c) The commissioner shall establish criteria that a targeted case management provider
178.7 must attest to in order to demonstrate the safety or efficacy of delivering the service via
178.8 interactive video. The attestation may include that the case management provider has:

178.9 (1) written policies and procedures specific to interactive video services that are regularly
178.10 reviewed and updated;

178.11 (2) policies and procedures that adequately address client safety before, during, and after
178.12 the interactive video services are rendered;

178.13 (3) established protocols addressing how and when to discontinue interactive video
178.14 services; and

178.15 (4) established a quality assurance process related to interactive video services.

178.16 (d) As a condition of payment, the targeted case management provider must document
178.17 the following for each occurrence of targeted case management provided by interactive
178.18 video:

178.19 (1) the time the service began and the time the service ended, including an a.m. and p.m.
178.20 designation;

178.21 (2) the basis for determining that interactive video is an appropriate and effective means
178.22 for delivering the service to the person receiving case management services;

178.23 (3) the mode of transmission of the interactive video services and records evidencing
178.24 that a particular mode of transmission was utilized;

178.25 (4) the location of the originating site and the distant site; and

178.26 (5) compliance with the criteria attested to by the targeted case management provider
178.27 as provided in paragraph (c).

178.28 **EFFECTIVE DATE.** This section is effective three months after federal approval.

179.1 Sec. 18. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
179.2 to read:

179.3 Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance
179.4 covers post-arrest community-based service coordination for an individual who:

179.5 (1) has been identified as having a mental illness or substance use disorder using a
179.6 screening tool approved by the commissioner;

179.7 (2) does not require the security of a public detention facility and is not considered an
179.8 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
179.9 435.1010;

179.10 (3) meets the eligibility requirements in section 256B.056; and

179.11 (4) has agreed to participate in post-arrest community-based service coordination through
179.12 a diversion contract in lieu of incarceration.

179.13 (b) Post-arrest community-based service coordination means navigating services to
179.14 address a client's mental health, chemical health, social, economic, and housing needs, or
179.15 any other activity targeted at reducing the incidence of jail utilization and connecting
179.16 individuals with existing covered services available to them, including, but not limited to,
179.17 targeted case management, waiver case management, or care coordination.

179.18 (c) Post-arrest community-based service coordination must be provided by individuals
179.19 who are qualified under one of the following criteria:

179.20 (1) a licensed mental health professional as defined in section 245.462, subdivision 18,
179.21 clauses (1) to (6);

179.22 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
179.23 under the clinical supervision of a mental health professional; or

179.24 (3) a certified peer specialist under section 256B.0615, working under the clinical
179.25 supervision of a mental health professional.

179.26 (d) Reimbursement must be made in 15-minute increments and allowed for up to 60
179.27 days following the initial determination of eligibility.

179.28 (e) Providers of post-arrest community-based service coordination shall annually report
179.29 to the commissioner on the number of individuals served, and number of the
179.30 community-based services that were accessed by recipients. The commissioner shall ensure
179.31 that services and payments provided under post-arrest community-based service coordination

180.1 do not duplicate services or payments provided under section 256B.0625, subdivision 20,
180.2 256B.0753, 256B.0755, or 256B.0757.

180.3 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
180.4 post-arrest community-based service coordination services shall be provided by the recipient's
180.5 county of residence, from sources other than federal funds or funds used to match other
180.6 federal funds.

180.7 **EFFECTIVE DATE.** This section is effective three months after federal approval.

180.8 Sec. 19. Minnesota Statutes 2016, section 256B.0625, subdivision 57, is amended to read:

180.9 Subd. 57. **Payment for Part B Medicare crossover claims.** (a) Effective for services
180.10 provided on or after January 1, 2012, medical assistance payment for an enrollee's
180.11 cost-sharing associated with Medicare Part B is limited to an amount up to the medical
180.12 assistance total allowed, when the medical assistance rate exceeds the amount paid by
180.13 Medicare.

180.14 (b) Excluded from this limitation are payments for mental health services and payments
180.15 for dialysis services provided to end-stage renal disease patients. The exclusion for mental
180.16 health services does not apply to payments for physician services provided by psychiatrists
180.17 and advanced practice nurses with a specialty in mental health.

180.18 (c) Excluded from this limitation are payments to federally qualified health centers,
180.19 Indian Health Services, and rural health clinics.

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

180.21 Sec. 20. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

180.22 Subd. 64. **Investigational drugs, biological products, and devices.** (a) Medical
180.23 assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do
180.24 not cover costs incidental to, associated with, or resulting from the use of investigational
180.25 drugs, biological products, or devices as defined in section 151.375.

180.26 (b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program
180.27 if all the following conditions are met:

180.28 (1) the use of stiripentol is determined to be medically necessary;

180.29 (2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether
180.30 an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating
180.31 partial epilepsy in infancy due to an SCN2A genetic mutation;

181.1 (3) all other available covered prescription medications that are medically necessary for
 181.2 the enrollee have been tried without successful outcomes; and

181.3 (4) the United States Food and Drug Administration has approved the treating physician's
 181.4 individual patient investigational new drug application (IND) for the use of stiripentol for
 181.5 treatment.

181.6 This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

181.7 Sec. 21. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

181.8 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
 181.9 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
 181.10 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
 181.11 a format determined by the commissioner, information and documentation that includes,
 181.12 but is not limited to, the following:

181.13 (1) the personal care assistance provider agency's current contact information including
 181.14 address, telephone number, and e-mail address;

181.15 (2) proof of surety bond coverage for each location providing services. Upon new
 181.16 enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and
 181.17 including \$300,000, the provider agency must purchase a surety bond of \$50,000. If the
 181.18 Medicaid revenue in the previous year is over \$300,000, the provider agency must purchase
 181.19 a surety bond of \$100,000. The surety bond must be in a form approved by the commissioner,
 181.20 must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim
 181.21 on the bond;

181.22 (3) proof of fidelity bond coverage in the amount of \$20,000 for each business location
 181.23 providing service;

181.24 (4) proof of workers' compensation insurance coverage identifying the business address
 181.25 where PCA services are provided from;

181.26 (5) proof of liability insurance coverage identifying the business address where PCA
 181.27 services are provided from and naming the department as a certificate holder;

181.28 ~~(6) a description of the personal care assistance provider agency's organization identifying~~
 181.29 ~~the names of all owners, managing employees, staff, board of directors, and the affiliations~~
 181.30 ~~of the directors, owners, or staff to other service providers;~~

181.31 ~~(7)~~ (6) a copy of the personal care assistance provider agency's written policies and
 181.32 procedures including: hiring of employees; training requirements; service delivery; and

182.1 employee and consumer safety including process for notification and resolution of consumer
182.2 grievances, identification and prevention of communicable diseases, and employee
182.3 misconduct;

182.4 ~~(8)~~ (7) copies of all other forms the personal care assistance provider agency uses in the
182.5 course of daily business including, but not limited to:

182.6 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
182.7 varies from the standard time sheet for personal care assistance services approved by the
182.8 commissioner, and a letter requesting approval of the personal care assistance provider
182.9 agency's nonstandard time sheet;

182.10 (ii) the personal care assistance provider agency's template for the personal care assistance
182.11 care plan; and

182.12 (iii) the personal care assistance provider agency's template for the written agreement
182.13 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

182.14 ~~(9)~~ (8) a list of all training and classes that the personal care assistance provider agency
182.15 requires of its staff providing personal care assistance services;

182.16 ~~(10)~~ (9) documentation that the personal care assistance provider agency and staff have
182.17 successfully completed all the training required by this section;

182.18 ~~(11)~~ (10) documentation of the agency's marketing practices;

182.19 ~~(12)~~ (11) disclosure of ownership, leasing, or management of all residential properties
182.20 that is used or could be used for providing home care services;

182.21 ~~(13)~~ (12) documentation that the agency will use the following percentages of revenue
182.22 generated from the medical assistance rate paid for personal care assistance services for
182.23 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
182.24 care assistance choice option and 72.5 percent of revenue from other personal care assistance
182.25 providers. The revenue generated by the qualified professional and the reasonable costs
182.26 associated with the qualified professional shall not be used in making this calculation; and

182.27 ~~(14)~~ (13) effective May 15, 2010, documentation that the agency does not burden
182.28 recipients' free exercise of their right to choose service providers by requiring personal care
182.29 assistants to sign an agreement not to work with any particular personal care assistance
182.30 recipient or for another personal care assistance provider agency after leaving the agency
182.31 and that the agency is not taking action on any such agreements or requirements regardless
182.32 of the date signed.

183.1 (b) Personal care assistance provider agencies shall provide the information specified
183.2 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
183.3 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
183.4 the information specified in paragraph (a) from all personal care assistance providers
183.5 beginning July 1, 2009.

183.6 (c) All personal care assistance provider agencies shall require all employees in
183.7 management and supervisory positions and owners of the agency who are active in the
183.8 day-to-day management and operations of the agency to complete mandatory training as
183.9 determined by the commissioner before submitting an application for enrollment of the
183.10 agency as a provider. All personal care assistance provider agencies shall also require
183.11 qualified professionals to complete the training required by subdivision 13 before submitting
183.12 an application for enrollment of the agency as a provider. Employees in management and
183.13 supervisory positions and owners who are active in the day-to-day operations of an agency
183.14 who have completed the required training as an employee with a personal care assistance
183.15 provider agency do not need to repeat the required training if they are hired by another
183.16 agency, if they have completed the training within the past three years. By September 1,
183.17 2010, the required training must be available with meaningful access according to title VI
183.18 of the Civil Rights Act and federal regulations adopted under that law or any guidance from
183.19 the United States Health and Human Services Department. The required training must be
183.20 available online or by electronic remote connection. The required training must provide for
183.21 competency testing. Personal care assistance provider agency billing staff shall complete
183.22 training about personal care assistance program financial management. This training is
183.23 effective July 1, 2009. Any personal care assistance provider agency enrolled before that
183.24 date shall, if it has not already, complete the provider training within 18 months of July 1,
183.25 2009. Any new owners or employees in management and supervisory positions involved
183.26 in the day-to-day operations are required to complete mandatory training as a requisite of
183.27 working for the agency. Personal care assistance provider agencies certified for participation
183.28 in Medicare as home health agencies are exempt from the training required in this
183.29 subdivision. When available, Medicare-certified home health agency owners, supervisors,
183.30 or managers must successfully complete the competency test.

183.31 (d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability
183.32 insurance required by this subdivision must be maintained continuously. After initial
183.33 enrollment, a provider must submit proof of bonds and required coverages at any time at
183.34 the request of the commissioner. Services provided while there are lapses in coverage are
183.35 not eligible for payment. Lapses in coverage may result in sanctions, including termination.

184.1 The commissioner shall send instructions and a due date to submit the requested information
184.2 to the personal care assistance provider agency.

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

184.4 Sec. 22. Minnesota Statutes 2016, section 256B.072, is amended to read:

184.5 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**
184.6 **SYSTEM.**

184.7 (a) The commissioner of human services shall establish a performance reporting system
184.8 for health care providers who provide health care services to public program recipients
184.9 covered under chapters 256B, 256D, and 256L, reporting separately for managed care and
184.10 fee-for-service recipients.

184.11 (b) The measures used for the performance reporting system for medical groups shall
184.12 may include measures of care for asthma, diabetes, hypertension, and coronary artery disease
184.13 and measures of preventive care services. The measures used for the performance reporting
184.14 system for inpatient hospitals shall include measures of care for acute myocardial infarction,
184.15 heart failure, and pneumonia, and measures of care and prevention of surgical infections.
184.16 In the case of a medical group, the measures used shall be consistent with ~~measures published~~
184.17 ~~by nonprofit Minnesota or national organizations that produce and disseminate health care~~
184.18 ~~quality measures or evidence-based health care guidelines~~ section 62U.02, subdivision 1,
184.19 paragraph (a), clause (1). In the case of inpatient hospital measures, the commissioner shall
184.20 appoint the Minnesota Hospital Association and Stratis Health to advise on the development
184.21 of the performance measures to be used for hospital reporting. To enable a consistent
184.22 measurement process across the community, the commissioner may use measures of care
184.23 provided for patients in addition to those identified in paragraph (a). The commissioner
184.24 shall ensure collaboration with other health care reporting organizations so that the measures
184.25 described in this section are consistent with those reported by those organizations and used
184.26 by other purchasers in Minnesota.

184.27 (c) The commissioner may require providers to submit information in a required format
184.28 to a health care reporting organization or to cooperate with the information collection
184.29 procedures of that organization. The commissioner may collaborate with a reporting
184.30 organization to collect information reported and to prevent duplication of reporting.

184.31 (d) By October 1, 2007, and annually thereafter, the commissioner shall report through
184.32 a public Web site the results by medical groups and hospitals, where possible, of the measures
184.33 under this section, and shall compare the results by medical groups and hospitals for patients

185.1 enrolled in public programs to patients enrolled in private health plans. To achieve this
185.2 reporting, the commissioner may collaborate with a health care reporting organization that
185.3 operates a Web site suitable for this purpose.

185.4 (e) Performance measures must be stratified as provided under section 62U.02,
185.5 subdivision 1, paragraph ~~(b)~~ (c), and risk-adjusted as specified in section 62U.02, subdivision
185.6 3, paragraph (b).

185.7 (f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider
185.8 and appropriately adjust quality metrics and benchmarks for providers who primarily serve
185.9 socioeconomically complex patient populations and request to be scored on additional
185.10 measures in this subdivision. This applies to all Minnesota health care programs, including
185.11 for patient populations enrolled in health plans, county-based purchasing plans, or managed
185.12 care organizations and for value-based purchasing arrangements, including, but not limited
185.13 to, initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and
185.14 256B.0757. This section must be implemented and administered by the commissioner with
185.15 existing quality measurement staff and agency resources that are paid for from other
185.16 appropriations or funding sources.

185.17 Sec. 23. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

185.18 Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~
185.19 continue and expand a demonstration project established under this section to test alternative
185.20 and innovative integrated health care delivery systems partnerships, including accountable
185.21 care organizations that provide services to a specified patient population for an agreed-upon
185.22 total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop
185.23 a request for proposals for participation in the demonstration project in consultation with
185.24 hospitals, primary care providers, health plans, and other key stakeholders.

185.25 (b) In developing the request for proposals, the commissioner shall:

185.26 (1) establish uniform statewide methods of forecasting utilization and cost of care for
185.27 the appropriate Minnesota public program populations, to be used by the commissioner for
185.28 ~~the health care delivery system~~ integrated health partnership projects;

185.29 (2) identify key indicators of quality, access, patient satisfaction, and other performance
185.30 indicators that will be measured, in addition to indicators for measuring cost savings;

185.31 (3) allow maximum flexibility to encourage innovation and variation so that a variety
185.32 of provider collaborations are able to become ~~health care delivery systems~~ integrated health

186.1 partnerships, and may be customized for the special needs and barriers of patient populations
 186.2 experiencing health disparities due to social, economic, racial, or ethnic factors,;

186.3 (4) encourage and authorize different levels and types of financial risk;

186.4 (5) encourage and authorize projects representing a wide variety of geographic locations,
 186.5 patient populations, provider relationships, and care coordination models;

186.6 (6) encourage projects that involve close partnerships between the ~~health care delivery~~
 186.7 ~~system~~ integrated health partnership and counties and nonprofit agencies that provide services
 186.8 to patients enrolled with the ~~health care delivery system~~ integrated health partnership,
 186.9 including social services, public health, mental health, community-based services, and
 186.10 continuing care;

186.11 (7) encourage projects established by community hospitals, clinics, and other providers
 186.12 in rural communities;

186.13 (8) identify required covered services for a total cost of care model or services considered
 186.14 in whole or partially in an analysis of utilization for a risk/gain sharing model;

186.15 (9) establish a mechanism to monitor enrollment;

186.16 (10) establish quality standards for the ~~delivery system~~ integrated health partnership
 186.17 demonstrations that are appropriate for the particular patient population to be served; and

186.18 (11) encourage participation of privately insured population so as to create sufficient
 186.19 alignment in demonstration systems.

186.20 (c) To be eligible to participate in ~~the demonstration project~~ an integrated health
 186.21 partnership, a health care delivery system must:

186.22 (1) provide required covered services and care coordination to recipients enrolled in the
 186.23 ~~health care delivery system~~ integrated health partnership;

186.24 (2) establish a process to monitor enrollment and ensure the quality of care provided;

186.25 (3) in cooperation with counties and community social service agencies, coordinate the
 186.26 delivery of health care services with existing social services programs;

186.27 (4) provide a system for advocacy and consumer protection; and

186.28 (5) adopt innovative and cost-effective methods of care delivery and coordination, which
 186.29 may include the use of allied health professionals, telemedicine, patient educators, care
 186.30 coordinators, and community health workers.

187.1 (d) ~~A health care delivery system~~ An integrated health partnership demonstration may
 187.2 be formed by the following groups of providers of services and suppliers if they have
 187.3 established a mechanism for shared governance:

187.4 (1) professionals in group practice arrangements;

187.5 (2) networks of individual practices of professionals;

187.6 (3) partnerships or joint venture arrangements between hospitals and health care
 187.7 professionals;

187.8 (4) hospitals employing professionals; and

187.9 (5) other groups of providers of services and suppliers as the commissioner determines
 187.10 appropriate.

187.11 A managed care plan or county-based purchasing plan may participate in this
 187.12 demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

187.13 ~~A health care delivery system~~ An integrated health partnership may contract with a
 187.14 managed care plan or a county-based purchasing plan to provide administrative services,
 187.15 including the administration of a payment system using the payment methods established
 187.16 by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

187.17 (e) The commissioner may require ~~a health care delivery system~~ an integrated health
 187.18 partnership to enter into additional third-party contractual relationships for the assessment
 187.19 of risk and purchase of stop loss insurance or another form of insurance risk management
 187.20 related to the delivery of care described in paragraph (c).

187.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

187.22 Sec. 24. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

187.23 Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships
 187.24 must accept responsibility for the quality of care based on standards established under
 187.25 subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services
 187.26 provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability
 187.27 standards must be appropriate to the particular population served.

187.28 (b) ~~A health care delivery system~~ An integrated health partnership may contract and
 187.29 coordinate with providers and clinics for the delivery of services and shall contract with
 187.30 community health clinics, federally qualified health centers, community mental health
 187.31 centers or programs, county agencies, and rural clinics to the extent practicable.

188.1 (c) ~~A health care delivery system~~ An integrated health partnership must indicate how it
 188.2 will coordinate with other services affecting its patients' health, quality of care, and cost of
 188.3 care that are provided by other providers, county agencies, and other organizations in the
 188.4 local service area. The ~~health care delivery system~~ integrated health partnership must indicate
 188.5 how it will engage other providers, counties, and organizations, including county-based
 188.6 purchasing plans, that provide services to patients of the ~~health care delivery system~~
 188.7 integrated health partnership on issues related to local population health, including applicable
 188.8 local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated
 188.9 health partnership must describe how local providers, counties, organizations, including
 188.10 county-based purchasing plans, and other relevant purchasers were consulted in developing
 188.11 the application to participate in the demonstration project.

188.12 Sec. 25. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

188.13 Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery~~
 188.14 ~~systems~~ integrated health partnerships, the commissioner shall establish a total cost of care
 188.15 benchmark or a risk/gain sharing payment model to be paid for services provided to the
 188.16 recipients enrolled in a ~~health care delivery system~~ an integrated health partnership.

188.17 (b) The payment system may include incentive payments to ~~health care delivery systems~~
 188.18 integrated health partnerships that meet or exceed annual quality and performance targets
 188.19 realized through the coordination of care.

188.20 (c) An amount equal to the savings realized to the general fund as a result of the
 188.21 demonstration project shall be transferred each fiscal year to the health care access fund.

188.22 (d) The payment system shall include a population-based payment that supports care
 188.23 coordination services for all enrollees served by the integrated health partnerships, and is
 188.24 risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with
 188.25 chronic conditions, limited English skills, cultural differences, or other barriers to health
 188.26 care. The population-based payment shall be a per member, per month payment paid at least
 188.27 on a quarterly basis. Integrated health partnerships receiving this payment must continue
 188.28 to meet cost and quality metrics under the program to maintain eligibility for the
 188.29 population-based payment. An integrated health partnership is eligible to receive a payment
 188.30 under this paragraph even if the partnership is not participating in a risk-based or gain-sharing
 188.31 payment model and regardless of the size of the patient population served by the integrated
 188.32 health partnership. Any integrated health partnership participant certified as a health care
 188.33 home under section 256B.0751 that agrees to a payment method that includes
 188.34 population-based payments for care coordination is not eligible to receive health care home

189.1 payment or care coordination fee authorized under section 62U.03 or 256B.0753, subdivision
189.2 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical
189.3 assistance or MinnesotaCare recipients enrolled or attributed to the integrated health
189.4 partnership under this demonstration.

189.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

189.6 Sec. 26. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision
189.7 to read:

189.8 Subd. 9. **Patient incentives.** The commissioner may authorize an integrated health
189.9 partnership to provide financial incentives for patients to:

189.10 (1) see a primary care provider for an initial health assessment;

189.11 (2) maintain a continuous relationship with the primary care provider; and

189.12 (3) participate in ongoing health improvement and coordination of care activities.

189.13 Sec. 27. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision
189.14 to read:

189.15 Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal
189.16 approval, contact made for targeted case management by interactive video shall be eligible
189.17 for payment under subdivision 6 if:

189.18 (1) the person receiving targeted case management services is residing in:

189.19 (i) a hospital;

189.20 (ii) a nursing facility; or

189.21 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
189.22 establishment or lodging establishment that provides supportive services or health supervision
189.23 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

189.24 (2) interactive video is in the best interests of the person and is deemed appropriate by
189.25 the person receiving targeted case management or the person's legal guardian, the case
189.26 management provider, and the provider operating the setting where the person is residing;

189.27 (3) the use of interactive video is approved as part of the person's written personal service
189.28 or case plan; and

189.29 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
189.30 required face-to-face contact.

190.1 (b) The person receiving targeted case management or the person's legal guardian has
190.2 the right to choose and consent to the use of interactive video under this subdivision and
190.3 has the right to refuse the use of interactive video at any time.

190.4 (c) The commissioner shall establish criteria that a targeted case management provider
190.5 must attest to in order to demonstrate the safety or efficacy of delivering the service via
190.6 interactive video. The attestation may include that the case management provider has:

190.7 (1) written policies and procedures specific to interactive video services that are regularly
190.8 reviewed and updated;

190.9 (2) policies and procedures that adequately address client safety before, during, and after
190.10 the interactive video services are rendered;

190.11 (3) established protocols addressing how and when to discontinue interactive video
190.12 services; and

190.13 (4) established a quality assurance process related to interactive video services.

190.14 (d) As a condition of payment, the targeted case management provider must document
190.15 the following for each occurrence of targeted case management provided by interactive
190.16 video:

190.17 (1) the time the service began and the time the service ended, including an a.m. and p.m.
190.18 designation;

190.19 (2) the basis for determining that interactive video is an appropriate and effective means
190.20 for delivering the service to the person receiving case management services;

190.21 (3) the mode of transmission of the interactive video services and records evidencing
190.22 that a particular mode of transmission was utilized;

190.23 (4) the location of the originating site and the distant site; and

190.24 (5) compliance with the criteria attested to by the targeted case management provider
190.25 as provided in paragraph (c).

190.26 **EFFECTIVE DATE.** This section is effective three months after federal approval.

190.27 Sec. 28. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

190.28 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
190.29 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
190.30 payment limit for nonstate government hospitals. The commissioner shall then determine
190.31 the amount of a supplemental payment to Hennepin County Medical Center and Regions

191.1 Hospital for these services that would increase medical assistance spending in this category
191.2 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
191.3 In making this determination, the commissioner shall allot the available increases between
191.4 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
191.5 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
191.6 shall adjust this allotment as necessary based on federal approvals, the amount of
191.7 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
191.8 in order to maximize the additional total payments. The commissioner shall inform Hennepin
191.9 County and Ramsey County of the periodic intergovernmental transfers necessary to match
191.10 federal Medicaid payments available under this subdivision in order to make supplementary
191.11 medical assistance payments to Hennepin County Medical Center and Regions Hospital
191.12 equal to an amount that when combined with existing medical assistance payments to
191.13 nonstate governmental hospitals would increase total payments to hospitals in this category
191.14 for outpatient services to the aggregate upper payment limit for all hospitals in this category
191.15 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
191.16 supplementary payments to Hennepin County Medical Center and Regions Hospital.

191.17 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
191.18 determine an upper payment limit for physicians and other billing professionals affiliated
191.19 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit
191.20 shall be based on the average commercial rate or be determined using another method
191.21 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
191.22 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers
191.23 necessary to match the federal Medicaid payments available under this subdivision in order
191.24 to make supplementary payments to physicians and other billing professionals affiliated
191.25 with Hennepin County Medical Center and to make supplementary payments to physicians
191.26 and other billing professionals affiliated with Regions Hospital through HealthPartners
191.27 Medical Group equal to the difference between the established medical assistance payment
191.28 for physician and other billing professional services and the upper payment limit. Upon
191.29 receipt of these periodic transfers, the commissioner shall make supplementary payments
191.30 to physicians and other billing professionals affiliated with Hennepin County Medical Center
191.31 and shall make supplementary payments to physicians and other billing professionals
191.32 affiliated with Regions Hospital through HealthPartners Medical Group.

191.33 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly
191.34 voluntary intergovernmental transfers to the commissioner in amounts not to exceed
191.35 \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.

192.1 The commissioner shall increase the medical assistance capitation payments to any licensed
192.2 health plan under contract with the medical assistance program that agrees to make enhanced
192.3 payments to Hennepin County Medical Center or Regions Hospital. The increase shall be
192.4 in an amount equal to the annual value of the monthly transfers plus federal financial
192.5 participation, with each health plan receiving its pro rata share of the increase based on the
192.6 pro rata share of medical assistance admissions to Hennepin County Medical Center and
192.7 Regions Hospital by those plans. For the purposes of this paragraph, "the base amount"
192.8 means the total annual value of increased medical assistance capitation payments under this
192.9 paragraph in state fiscal year 2018. For managed care contracts beginning on or after July
192.10 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance
192.11 capitation payments under this paragraph by an amount equal to ten percent of the base
192.12 amount, and by an additional ten percent of the base amount for each subsequent contract
192.13 year until June 30, 2025. Upon the request of the commissioner, health plans shall submit
192.14 individual-level cost data for verification purposes. The commissioner may ratably reduce
192.15 these payments on a pro rata basis in order to satisfy federal requirements for actuarial
192.16 soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed
192.17 health plan that receives increased medical assistance capitation payments under the
192.18 intergovernmental transfer described in this paragraph shall increase its medical assistance
192.19 payments to Hennepin County Medical Center and Regions Hospital by the same amount
192.20 as the increased payments received in the capitation payment described in this paragraph.
192.21 This paragraph expires on July 1, 2025.

192.22 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
192.23 determine an upper payment limit for ambulance services affiliated with Hennepin County
192.24 Medical Center and the city of St. Paul. The upper payment limit shall be based on the
192.25 average commercial rate or be determined using another method acceptable to the Centers
192.26 for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and
192.27 the city of St. Paul of the periodic intergovernmental transfers necessary to match the federal
192.28 Medicaid payments available under this subdivision in order to make supplementary
192.29 payments to Hennepin County Medical Center and the city of St. Paul equal to the difference
192.30 between the established medical assistance payment for ambulance services and the upper
192.31 payment limit. Upon receipt of these periodic transfers, the commissioner shall make
192.32 supplementary payments to Hennepin County Medical Center and the city of St. Paul.

192.33 (e) The commissioner shall inform the transferring governmental entities on an ongoing
192.34 basis of the need for any changes needed in the intergovernmental transfers in order to

193.1 continue the payments under paragraphs (a) to (d), at their maximum level, including
 193.2 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

193.3 (f) The payments in paragraphs (a) to (d) shall be implemented independently of each
 193.4 other, subject to federal approval and to the receipt of transfers under subdivision 3.

193.5 Sec. 29. Minnesota Statutes 2016, section 256B.69, subdivision 9e, is amended to read:

193.6 Subd. 9e. **Financial audits.** ~~(a) The legislative auditor shall conduct or contract with~~
 193.7 ~~vendors to conduct independent third-party financial audits of the information required to~~
 193.8 ~~be provided by~~ audit managed care plans and county-based purchasing plans under
 193.9 ~~subdivision 9e, paragraph (b). The audits by the vendors shall be conducted as vendor~~
 193.10 ~~resources permit and in accordance with generally accepted government auditing standards~~
 193.11 ~~issued by the United States Government Accountability Office. The contract with the vendors~~
 193.12 ~~shall be designed and administered so as to render the independent third-party audits eligible~~
 193.13 ~~for a federal subsidy, if available. The contract shall require the audits to include a~~
 193.14 ~~determination of compliance with the federal Medicaid rate certification process to determine~~
 193.15 if a managed care plan or county-based purchasing plan used public money in compliance
 193.16 with federal and state laws, rules, and in accordance with provisions in the plan's contract
 193.17 with the commissioner. The legislative auditor shall conduct the audits in accordance with
 193.18 section 3.972, subdivision 2b.

193.19 ~~(b) For purposes of this subdivision, "independent third-party" means a vendor that is~~
 193.20 ~~independent in accordance with government auditing standards issued by the United States~~
 193.21 ~~Government Accountability Office.~~

193.22 Sec. 30. Minnesota Statutes 2016, section 256B.76, subdivision 1, is amended to read:

193.23 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after
 193.24 October 1, 1992, the commissioner shall make payments for physician services as follows:

193.25 (1) payment for level one Centers for Medicare and Medicaid Services' common
 193.26 procedural coding system codes titled "office and other outpatient services," "preventive
 193.27 medicine new and established patient," "delivery, antepartum, and postpartum care," "critical
 193.28 care," cesarean delivery and pharmacologic management provided to psychiatric patients,
 193.29 and level three codes for enhanced services for prenatal high risk, shall be paid at the lower
 193.30 of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the
 193.31 rate on any procedure code within these categories is different than the rate that would have
 193.32 been paid under the methodology in section 256B.74, subdivision 2, then the larger rate
 193.33 shall be paid;

194.1 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
194.2 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

194.3 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
194.4 percentile of 1989, less the percent in aggregate necessary to equal the above increases
194.5 except that payment rates for home health agency services shall be the rates in effect on
194.6 September 30, 1992.

194.7 (b) Effective for services rendered on or after January 1, 2000, payment rates for physician
194.8 and professional services shall be increased by three percent over the rates in effect on
194.9 December 31, 1999, except for home health agency and family planning agency services.
194.10 The increases in this paragraph shall be implemented January 1, 2000, for managed care.

194.11 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
194.12 and professional services shall be reduced by five percent, except that for the period July
194.13 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical
194.14 assistance and general assistance medical care programs, over the rates in effect on June
194.15 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
194.16 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
194.17 advanced practice nurses, or physician assistants in a family planning agency or in one of
194.18 the following primary care practices: general practice, general internal medicine, general
194.19 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in
194.20 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
194.21 Indian health services. Effective October 1, 2009, payments made to managed care plans
194.22 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
194.23 reflect the payment reduction described in this paragraph.

194.24 (d) Effective for services rendered on or after July 1, 2010, payment rates for physician
194.25 and professional services shall be reduced an additional seven percent over the five percent
194.26 reduction in rates described in paragraph (c). This additional reduction does not apply to
194.27 physical therapy services, occupational therapy services, and speech pathology and related
194.28 services provided on or after July 1, 2010. This additional reduction does not apply to
194.29 physician services billed by a psychiatrist or an advanced practice nurse with a specialty in
194.30 mental health. Effective October 1, 2010, payments made to managed care plans and
194.31 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
194.32 the payment reduction described in this paragraph.

194.33 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,
194.34 payment rates for physician and professional services shall be reduced three percent from

195.1 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy
195.2 services, occupational therapy services, and speech pathology and related services.

195.3 (f) Effective for services rendered on or after September 1, 2014, payment rates for
195.4 physician and professional services, including physical therapy, occupational therapy, speech
195.5 pathology, and mental health services shall be increased by five percent from the rates in
195.6 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
195.7 include in the base rate for August 31, 2014, the rate increase provided under section
195.8 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
195.9 rural health centers, and Indian health services. Payments made to managed care plans and
195.10 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

195.11 (g) Effective for services rendered on or after July 1, 2015, payment rates for physical
195.12 therapy, occupational therapy, and speech pathology and related services provided by a
195.13 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
195.14 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments
195.15 made to managed care plans and county-based purchasing plans shall not be adjusted to
195.16 reflect payments under this paragraph.

195.17 (h) Effective for services provided on or after July 1, 2017, through June 30, 2019,
195.18 payment rates for physician and professional services, including physical therapy,
195.19 occupational therapy and speech pathology, and related services provided by a hospital
195.20 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
195.21 shall be reduced by 2.3 percent, and effective for services provided on or after July 1, 2019,
195.22 payments shall be reduced by three percent. Payments made to managed care plans and
195.23 county-based purchasing plans shall be adjusted to reflect the rate reductions in this paragraph
195.24 effective January 1, 2018.

195.25 Sec. 31. Minnesota Statutes 2016, section 256B.76, subdivision 2, is amended to read:

195.26 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
195.27 1, 1992, the commissioner shall make payments for dental services as follows:

195.28 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent
195.29 above the rate in effect on June 30, 1992; and

195.30 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile
195.31 of 1989, less the percent in aggregate necessary to equal the above increases.

195.32 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
195.33 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

196.1 (c) Effective for services rendered on or after January 1, 2000, payment rates for dental
196.2 services shall be increased by three percent over the rates in effect on December 31, 1999.

196.3 (d) Effective for services provided on or after January 1, 2002, payment for diagnostic
196.4 examinations and dental x-rays provided to children under age 21 shall be the lower of (1)
196.5 the submitted charge, or (2) 85 percent of median 1999 charges.

196.6 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000,
196.7 for managed care.

196.8 (f) Effective for dental services rendered on or after October 1, 2010, by a state-operated
196.9 dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare
196.10 principles of reimbursement. This payment shall be effective for services rendered on or
196.11 after January 1, 2011, to recipients enrolled in managed care plans or county-based
196.12 purchasing plans.

196.13 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in
196.14 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a
196.15 supplemental state payment equal to the difference between the total payments in paragraph
196.16 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the
196.17 operation of the dental clinics.

196.18 ~~(h) If the cost-based payment system for state-operated dental clinics described in~~
196.19 ~~paragraph (f) does not receive federal approval, then state-operated dental clinics shall be~~
196.20 ~~designated as critical access dental providers under subdivision 4, paragraph (b), and shall~~
196.21 ~~receive the critical access dental reimbursement rate as described under subdivision 4,~~
196.22 ~~paragraph (a).~~

196.23 ~~(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013,~~
196.24 ~~payment rates for dental services shall be reduced by three percent. This reduction does not~~
196.25 ~~apply to state-operated dental clinics in paragraph (f).~~

196.26 ~~(j)~~ (h) Effective for services rendered on or after January 1, 2014, payment rates for
196.27 dental services shall be increased by five percent from the rates in effect on December 31,
196.28 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally
196.29 qualified health centers, rural health centers, and Indian health services. Effective January
196.30 1, 2014, payments made to managed care plans and county-based purchasing plans under
196.31 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in
196.32 this paragraph.

197.1 ~~(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,~~
 197.2 ~~the commissioner shall increase payment rates for services furnished by dental providers~~
 197.3 ~~located outside of the seven-county metropolitan area by the maximum percentage possible~~
 197.4 ~~above the rates in effect on June 30, 2015, while remaining within the limits of funding~~
 197.5 ~~appropriated for this purpose. This increase does not apply to state-operated dental clinics~~
 197.6 ~~in paragraph (f), federally qualified health centers, rural health centers, and Indian health~~
 197.7 ~~services. Effective January 1, 2016, through December 31, 2016, payments to managed care~~
 197.8 ~~plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect~~
 197.9 ~~the payment increase described in this paragraph. The commissioner shall require managed~~
 197.10 ~~care and county-based purchasing plans to pass on the full amount of the increase, in the~~
 197.11 ~~form of higher payment rates to dental providers located outside of the seven-county~~
 197.12 ~~metropolitan area.~~

197.13 ~~(k)~~ (i) Effective for services provided on or after January 1, 2017, through June 30, 2017,
 197.14 the commissioner shall increase payment rates by 9.65 percent for dental services provided
 197.15 outside of the seven-county metropolitan area. This increase does not apply to state-operated
 197.16 dental clinics in paragraph (f), federally qualified health centers, rural health centers, or
 197.17 Indian health services. Effective January 1, 2017, through June 30, 2017, payments to
 197.18 managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692
 197.19 shall reflect the payment increase described in this paragraph.

197.20 (j) Effective for services rendered on or after July 1, 2017, payment rates for dental
 197.21 services shall be increased by 25 percent. This increase does not apply to state-operated
 197.22 dental clinics in paragraph (f), federally qualified health centers, rural health centers, and
 197.23 Indian health services when an encounter rate is paid. Payments made to managed care
 197.24 plans and county-based purchasing plans shall not be adjusted to reflect the payment increase
 197.25 described in this paragraph.

197.26 Sec. 32. [256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC
 197.27 HEALTH NURSE HOME VISITS.

197.28 Effective for services provided on or after January 1, 2018, prenatal and postpartum
 197.29 follow-up home visits provided by public health nurses or registered nurses supervised by
 197.30 a public health nurse using evidence-based models shall be paid a minimum of \$140 per
 197.31 visit. Evidence-based postpartum follow-up home visits must be administered by home
 197.32 visiting programs that meet the United States Department of Health and Human Services
 197.33 criteria for evidence-based models and are identified by the commissioner of health as
 197.34 eligible to be implemented under the Maternal, Infant, and Early Childhood Home Visiting

198.1 program. Home visits must target mothers and their children beginning with prenatal visits
198.2 through age three for the child.

198.3 Sec. 33. Minnesota Statutes 2016, section 256B.766, is amended to read:

198.4 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

198.5 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
198.6 services, shall be reduced by three percent, except that for the period July 1, 2009, through
198.7 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
198.8 and general assistance medical care programs, prior to third-party liability and spenddown
198.9 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
198.10 occupational therapy services, and speech-language pathology and related services as basic
198.11 care services. The reduction in this paragraph shall apply to physical therapy services,
198.12 occupational therapy services, and speech-language pathology and related services provided
198.13 on or after July 1, 2010.

198.14 (b) Payments made to managed care plans and county-based purchasing plans shall be
198.15 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
198.16 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
198.17 to reflect the reduction effective July 1, 2010.

198.18 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
198.19 total payments for outpatient hospital facility fees shall be reduced by five percent from the
198.20 rates in effect on August 31, 2011.

198.21 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
198.22 total payments for ambulatory surgery centers facility fees, medical supplies and durable
198.23 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
198.24 renal dialysis services, laboratory services, public health nursing services, physical therapy
198.25 services, occupational therapy services, speech therapy services, eyeglasses not subject to
198.26 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
198.27 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
198.28 2011.

198.29 (e) Effective for services provided on or after September 1, 2014, payments for
198.30 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
198.31 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
198.32 and hearing aids not subject to a volume purchase contract shall be increased by three percent
198.33 and payments for outpatient hospital facility fees shall be increased by three percent.

199.1 Payments made to managed care plans and county-based purchasing plans shall not be
199.2 adjusted to reflect payments under this paragraph.

199.3 (f) Payments for medical supplies and durable medical equipment not subject to a volume
199.4 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
199.5 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
199.6 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
199.7 provided on or after July 1, 2015, shall be increased by three percent from the rates as
199.8 determined under paragraphs (i) and (j).

199.9 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
199.10 hospital facility fees, medical supplies and durable medical equipment not subject to a
199.11 volume purchase contract, prosthetics, and orthotics, ~~and laboratory services~~ to a hospital
199.12 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
199.13 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made
199.14 to managed care plans and county-based purchasing plans shall not be adjusted to reflect
199.15 payments under this paragraph.

199.16 (h) This section does not apply to physician and professional services, inpatient hospital
199.17 services, family planning services, mental health services, dental services, prescription
199.18 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
199.19 health services, and Medicare cost-sharing.

199.20 (i) Effective for services provided on or after July 1, 2015, the following categories of
199.21 durable medical equipment shall be individually priced items: enteral nutrition and supplies,
199.22 customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and
199.23 durable medical equipment repair and service. This paragraph does not apply to medical
199.24 supplies and durable medical equipment subject to a volume purchase contract, products
199.25 subject to the preferred diabetic testing supply program, and items provided to dually eligible
199.26 recipients when Medicare is the primary payer for the item. The commissioner shall not
199.27 apply any medical assistance rate reductions to durable medical equipment as a result of
199.28 Medicare competitive bidding.

199.29 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
199.30 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
199.31 as follows:

199.32 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
199.33 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
199.34 increased by 9.5 percent; and

200.1 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
200.2 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
200.3 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
200.4 being applied after calculation of any increased payment rate under clause (1).

200.5 This paragraph does not apply to medical supplies and durable medical equipment subject
200.6 to a volume purchase contract, products subject to the preferred diabetic testing supply
200.7 program, items provided to dually eligible recipients when Medicare is the primary payer
200.8 for the item, and individually priced items identified in paragraph (i). Payments made to
200.9 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
200.10 rate increases in this paragraph.

200.11 (k) Effective for services provided on or after July 1, 2017, through June 30, 2019,
200.12 payments for basic care services, including physical therapy services; occupational therapy
200.13 services; speech language pathology and related services; ambulatory surgical center facility
200.14 fees; medical supplies and durable medical equipment, not subject to a volume purchase
200.15 contract; prosthetics; orthotics; renal dialysis services; laboratory services; public health
200.16 nursing services; eyeglasses, not subject to a volume purchase contract; hearing aids, not
200.17 subject to a volume purchase contract; and anesthesia services shall be reduced by 2.3
200.18 percent and effective for services provided on or after July 1, 2019, payments shall be
200.19 reduced by three percent. Payments made to managed care plans and county-based purchasing
200.20 plans shall be adjusted to reflect the rate reduction in this paragraph effective January 1,
200.21 2018.

200.22 **EFFECTIVE DATE.** The amendment in paragraph (g) is effective the day following
200.23 final enactment.

200.24 Sec. 34. Minnesota Statutes 2016, section 256L.03, subdivision 1, is amended to read:

200.25 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
200.26 services reimbursed under chapter 256B, with the exception of special education services,
200.27 home care nursing services, adult dental care services other than services covered under
200.28 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation
200.29 services, personal care assistance and case management services, and nursing home or
200.30 intermediate care facilities services.

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

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

201.2 (d) For the purposes of covered health services under this section, "child" means an
 201.3 individual younger than 19 years of age.

201.4 Sec. 35. Minnesota Statutes 2016, section 256L.03, subdivision 1a, is amended to read:

201.5 Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible
 201.6 for coverage of all services that are eligible for reimbursement under the medical assistance
 201.7 program according to chapter 256B, except special education services and that abortion
 201.8 services under MinnesotaCare shall be limited as provided under subdivision 1. Children
 201.9 are exempt from the provisions of subdivision 5, regarding co-payments. Children who are
 201.10 lawfully residing in the United States but who are not "qualified noncitizens" under title IV
 201.11 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public
 201.12 Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all
 201.13 services provided under the medical assistance program according to chapter 256B.

201.14 Sec. 36. Minnesota Statutes 2016, section 256L.03, subdivision 5, is amended to read:

201.15 Subd. 5. **Cost-sharing.** ~~(a) Except as otherwise provided in this subdivision, the~~
 201.16 ~~MinnesotaCare benefit plan shall include the following cost-sharing requirements for all~~
 201.17 ~~enrollees:~~

201.18 ~~(1) \$3 per prescription for adult enrollees;~~

201.19 ~~(2) \$25 for eyeglasses for adult enrollees;~~

201.20 ~~(3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an~~
 201.21 ~~episode of service which is required because of a recipient's symptoms, diagnosis, or~~
 201.22 ~~established illness, and which is delivered in an ambulatory setting by a physician or~~
 201.23 ~~physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse,~~
 201.24 ~~audiologist, optician, or optometrist;~~

201.25 ~~(4) \$6 for nonemergency visits to a hospital-based emergency room for services provided~~
 201.26 ~~through December 31, 2010, and \$3.50 effective January 1, 2011; and~~

201.27 ~~(5) a family deductible equal to \$2.75 per month per family and adjusted annually by~~
 201.28 ~~the percentage increase in the medical care component of the CPI-U for the period of~~
 201.29 ~~September to September of the preceding calendar year, rounded to the next higher five~~
 201.30 ~~cent increment.~~

202.1 ~~(b) Paragraph (a) does~~ (a) Co-payments, coinsurance, and deductibles do not apply to
 202.2 children under the age of 21 and to American Indians as defined in Code of Federal
 202.3 Regulations, title 42, section ~~447.51~~ 600.5.

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

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

202.8 ~~(e) The commissioner, through the contracting process under section 256L.12, may~~
 202.9 ~~allow managed care plans and county-based purchasing plans to waive the family deductible~~
 202.10 ~~under paragraph (a), clause (5). The value of the family deductible shall not be included in~~
 202.11 ~~the capitation payment to managed care plans and county-based purchasing plans. Managed~~
 202.12 ~~care plans and county-based purchasing plans shall certify annually to the commissioner~~
 202.13 ~~the dollar value of the family deductible.~~

202.14 ~~(f)~~ (b) The commissioner shall ~~increase~~ adjust co-payments, coinsurance, and deductibles
 202.15 for covered services in a manner sufficient to ~~reduce~~ maintain the actuarial value of the
 202.16 benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to
 202.17 eligible recipients or services exempt from cost-sharing under state law. The cost-sharing
 202.18 changes described in this paragraph shall not be implemented prior to January 1, 2016.

202.19 ~~(g)~~ (c) The cost-sharing changes authorized under paragraph ~~(f)~~ (b) must satisfy the
 202.20 requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal
 202.21 Regulations, title 42, sections 600.510 and 600.520.

202.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

202.23 Sec. 37. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

202.24 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner
 202.25 shall establish a sliding fee scale to determine the percentage of monthly individual or family
 202.26 income that households at different income levels must pay to obtain coverage through the
 202.27 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly
 202.28 individual or family income.

202.29 (b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according
 202.30 to the premium scale specified in paragraph (d).

202.31 (c) Paragraph (b) does not apply to:

202.32 (1) children 20 years of age or younger; and

203.1 (2) individuals with household incomes below 35 percent of the federal poverty
203.2 guidelines.

203.3 (d) The following premium scale is established for each individual in the household who
203.4 is 21 years of age or older and enrolled in MinnesotaCare:

203.5	Federal Poverty Guideline	Less than	Individual Premium
203.6	Greater than or Equal to		Amount
203.7	35%	55%	\$4
203.8	55%	80%	\$6
203.9	80%	90%	\$8
203.10	90%	100%	\$10
203.11	100%	110%	\$12
203.12	110%	120%	\$14
203.13	120%	130%	\$15
203.14	130%	140%	\$16
203.15	140%	150%	\$25
203.16	150%	160%	\$29 <u>\$37</u>
203.17	160%	170%	\$33 <u>\$44</u>
203.18	170%	180%	\$38 <u>\$52</u>
203.19	180%	190%	\$43 <u>\$61</u>
203.20	190%	<u>200%</u>	\$50 <u>\$71</u>
203.21	<u>200%</u>		<u>\$80</u>

203.22 **EFFECTIVE DATE.** This section is effective August 1, 2015.

203.23 Sec. 38. **CAPITATION PAYMENT DELAY.**

203.24 (a) The commissioner of human services shall delay \$54,654,000 of the medical assistance
203.25 capitation payment to managed care plans and county-based purchasing plans due in April
203.26 2019 and all of the payment due in May 2019 and the payment due in April 2019 for special
203.27 needs basic care until July 1, 2019. The payment shall be made no earlier than July 1, 2019,
203.28 and no later than July 31, 2019.

203.29 (b) The commissioner of human services shall delay the medical assistance capitation
203.30 payment to managed care plans and county-based purchasing plans due in April 2021 and
203.31 May 2021 and the payment due in April 2021 for special needs basic care until July 1, 2021.
203.32 The payment shall be made no earlier than July 1, 2021, and no later than July 31, 2021.

204.1 Sec. 39. COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL.

204.2 The commissioner of human services shall seek federal approval that is necessary to
204.3 implement Minnesota Statutes, sections 256B.0621, subdivision 10; 256B.0924, subdivision
204.4 4a; and 256B.0625, subdivision 20b, for interactive video contact.

204.5 Sec. 40. LEGISLATIVE COMMISSION ON MANAGED CARE.

204.6 Subdivision 1. Establishment. (a) A legislative commission is created to study and
204.7 make recommendations to the legislature on issues relating to the competitive bidding
204.8 program and procurement process for the medical assistance and MinnesotaCare contracts
204.9 with managed care organizations for nonelderly, nondisabled adults and children enrollees.

204.10 (b) For purposes of this section, "managed care organization" means a demonstration
204.11 provider as defined under Minnesota Statutes, section 256B.69, subdivision 2.

204.12 Subd. 2. Membership. (a) The commission consists of:

204.13 (1) four members of the senate, two members appointed by the senate majority leader
204.14 and two members appointed by the senate minority leader;

204.15 (2) four members of the house of representatives, two members appointed by the speaker
204.16 of the house and two members appointed by the minority leader; and

204.17 (3) the commissioner of human services or the commissioner's designee.

204.18 (b) The appointing authorities must make their appointments by July 1, 2017.

204.19 (c) The ranking senator from the majority party appointed to the commission shall
204.20 convene the first meeting no later than September 1, 2017.

204.21 (d) The commission shall elect a chair among its members at the first meeting.

204.22 (e) Members serve without compensation or reimbursement for expenses, except that
204.23 legislative members may receive per diem and be reimbursed for expenses as provided in
204.24 the rules governing their respective bodies.

204.25 Subd. 3. Staff. The commissioner of human services shall provide staff and administrative
204.26 and research services, as needed, to the commission.

204.27 Subd. 4. Duties. (a) The commission shall study, review, and make recommendations
204.28 on the competitive bidding process for the managed care contracts that provide services to
204.29 the nonelderly, nondisabled adults and children enrolled in medical assistance and
204.30 MinnesotaCare. When reviewing the competitive bidding process, the commission shall
204.31 consider and make recommendations on the following:

205.1 (1) the number of geographic regions to be established for competitive bidding and each
205.2 procurement cycle and the criteria to be used in determining the minimum number of
205.3 managed care organizations to serve each region or statistical area;

205.4 (2) the specifications of the request for proposals, including whether managed care
205.5 organizations must address in their proposals priority areas identified by counties;

205.6 (3) the criteria to be used to determine whether managed care organizations will be
205.7 requested to provide a best and final offer;

205.8 (4) the evaluation process that the commissioner must consider when evaluating each
205.9 proposal, including the scoring weight to be given when there is a county board resolution
205.10 identifying a managed care organization preference, and whether consideration shall be
205.11 given to network adequacy for such services as dental, mental health, and primary care;

205.12 (5) the notification process to inform managed care organizations about the award
205.13 determinations, but before the contracts are signed;

205.14 (6) process for appealing the commissioner's decision on the selection of a managed
205.15 care plan or county-based purchasing plan in a county or counties; and

205.16 (7) whether an independent evaluation of the competitive bidding process is necessary,
205.17 and if so, what the evaluation should entail.

205.18 (b) The commissioner shall consider the frequency of the procurement process in terms
205.19 of how often the commissioner should conduct the procurement of managed care contracts
205.20 and whether procurement should be conducted on a statewide basis or at staggered times
205.21 for a limited number of counties within a specified region.

205.22 (c) The commission shall review proposed legislation that incorporates new federal
205.23 regulations into managed care statutes, including the recodification of the managed care
205.24 requirements in Minnesota Statutes, sections 256B.69 and 256B.692.

205.25 (d) The commission shall study, review, and make recommendations on a process that
205.26 meets federal regulations for ensuring that provider rate increases passed by the legislature
205.27 and incorporated into the capitated rates paid to managed care organizations are recognized
205.28 in the rates paid by the managed care organizations to the providers while still providing
205.29 managed care organizations the flexibility in negotiating rates paid to their provider networks.

205.30 (e) The commission shall consult with interested stakeholders and may solicit public
205.31 testimony, as deemed necessary.

206.1 Subd. 5. **Report.** (a) The commission shall report its recommendations to the chairs and
206.2 ranking minority members of the legislative committees with jurisdiction over health and
206.3 human services policy and finance by February 15, 2018. The report shall include any draft
206.4 legislation necessary to implement the recommendations.

206.5 (b) The commission shall provide preliminary recommendations to the commissioner
206.6 of human services to be used by the commissioner if the commissioner decides to conduct
206.7 a procurement for managed care contracts for the 2019 contract year.

206.8 Subd. 6. **Open meetings.** The commission is subject to Minnesota Statutes, section
206.9 3.055.

206.10 Subd. 7. **Expiration.** This section expires June 30, 2018.

206.11 Sec. 41. **REVISOR'S INSTRUCTION.**

206.12 The revisor of statutes, in the next edition of Minnesota Statutes, shall change the term
206.13 "health care delivery system" and similar terms to "integrated health partnership" and similar
206.14 terms, wherever it appears in Minnesota Statutes, section 256B.0755.

206.15 Sec. 42. **REPEALER.**

206.16 Minnesota Statutes 2016, sections 256B.0659, subdivision 22; 256B.19, subdivision 1c;
206.17 and 256B.64, are repealed.

206.18 **ARTICLE 5**

206.19 **HEALTH INSURANCE**

206.20 Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

206.21 Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in
206.22 other sections and which refer to accident and sickness or accident and health insurance
206.23 shall hereinafter be construed as referring to accident and sickness policy provisions. The
206.24 provisions of subdivision 2, clauses (4), (5), (6), (7), (8), (9), (10), and (12); subdivision 3,
206.25 clauses (1), (3), (4), (5), (6), and (7); subdivision 6; and subdivision 10 do not apply to
206.26 accident and sickness or accident and health insurance that are health plans defined in section
206.27 62A.011, subdivision 3.

206.28 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
206.29 renewed on or after January 1, 2018.

207.1 Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

207.2 Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain
207.3 a provision which permits continuation of coverage under the policy for the insured's ~~former~~
207.4 ~~spouse and dependent children upon~~ as defined in section 62Q.01, subdivision 2a, and
207.5 former spouse, who was covered on the day before entry of a valid decree of dissolution of
207.6 marriage. The coverage shall be continued until the earlier of the following dates:

207.7 (a) the date the insured's former spouse becomes covered under any other group health
207.8 plan; or

207.9 (b) the date coverage would otherwise terminate under the policy.

207.10 If the coverage is provided under a group policy, any required premium contributions
207.11 for the coverage shall be paid by the insured on a monthly basis to the group policyholder
207.12 for remittance to the insurer. The policy must require the group policyholder to, upon request,
207.13 provide the insured with written verification from the insurer of the cost of this coverage
207.14 promptly at the time of eligibility for this coverage and at any time during the continuation
207.15 period. In no event shall the amount of premium charged exceed 102 percent of the cost to
207.16 the plan for such period of coverage for other similarly situated spouses and dependent
207.17 children with respect to whom the marital relationship has not dissolved, without regard to
207.18 whether such cost is paid by the employer or employee.

207.19 Upon request by the insured's ~~former spouse or dependent child~~ children and former
207.20 spouse, who was covered on the day before entry of a valid decree of dissolution, a health
207.21 carrier must provide the instructions necessary to enable the child or former spouse to elect
207.22 continuation of coverage.

207.23 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
207.24 renewed on or after January 1, 2018.

207.25 Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

207.26 **62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.**

207.27 (a) A health plan company that provides coverage under a health plan for cancer
207.28 chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance
207.29 amount for a prescribed, orally administered anticancer medication that is used to kill or
207.30 slow the growth of cancerous cells than what the health plan requires for an intravenously
207.31 administered or injected cancer medication that is provided, regardless of formulation or
207.32 benefit category determination by the health plan company.

208.1 (b) A health plan company must not achieve compliance with this section by imposing
208.2 an increase in co-payment, deductible, or coinsurance amount for an intravenously
208.3 administered or injected cancer chemotherapy agent covered under the health plan.

208.4 (c) Nothing in this section shall be interpreted to prohibit a health plan company from
208.5 requiring prior authorization or imposing other appropriate utilization controls in approving
208.6 coverage for any chemotherapy.

208.7 (d) A plan offered by the commissioner of management and budget under section 43A.23
208.8 is deemed to be at parity and in compliance with this section.

208.9 (e) A health plan company is in compliance with this section if it does not include orally
208.10 administered anticancer medication in the fourth tier of its pharmacy benefit.

208.11 (f) A health plan company that provides coverage under a health plan for cancer
208.12 chemotherapy treatment must indicate the level of coverage for orally administered anticancer
208.13 medication within its pharmacy benefit filing with the commissioner.

208.14 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to health
208.15 plans offered, sold, issued, or renewed on or after that date.

208.16 Sec. 4. Minnesota Statutes 2016, section 62A.65, subdivision 2, is amended to read:

208.17 Subd. 2. **Guaranteed renewal.** (a) No individual health plan may be offered, sold,
208.18 issued, or renewed to a Minnesota resident unless the health plan provides that the plan is
208.19 guaranteed renewable at a premium rate that does not take into account the claims experience
208.20 or any change in the health status of any covered person that occurred after the initial issuance
208.21 of the health plan to the person. The premium rate upon renewal must also otherwise comply
208.22 with this section. A health carrier must not refuse to renew an individual health plan, except
208.23 for nonpayment of premiums, fraud, or intentional misrepresentation of a material fact.

208.24 (b) At the time of renewal, a health carrier may elect to discontinue health plan coverage
208.25 of an individual in the individual market, only in one or more of the following situations:

208.26 (1) the health carrier is ceasing to offer individual health plan coverage in the individual
208.27 market in accordance with sections 62A.65, subdivision 8, and 62E.11, subdivision 9, and
208.28 federal law;

208.29 (2) for network plans, the individual no longer resides, lives, or works in the service
208.30 area of the health carrier, or the area for which the health carrier is authorized to do business,
208.31 but only if coverage is terminated uniformly without regard to any health status-related
208.32 factor of covered individuals; or

209.1 (3) a decision by the health carrier to discontinue offering a particular type of individual
 209.2 health plan if the health carrier:

209.3 (i) provides notice in writing to each individual provided coverage of that type of health
 209.4 plan at least 90 days before the date the coverage will be discontinued;

209.5 (ii) provides notice to the commissioner of commerce at least 30 business days before
 209.6 the health carrier gives notice to the individuals;

209.7 (iii) offers to each covered individual, on a guaranteed issue basis, the option to purchase
 209.8 any other individual health plan currently being offered by the health carrier or a related
 209.9 health carrier for individuals in the individual market; and

209.10 (iv) acts uniformly without regard to any health status-related factor of covered individuals
 209.11 or dependents of covered individuals who may become eligible for coverage.

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

209.13 Sec. 5. Minnesota Statutes 2016, section 62A.65, is amended by adding a subdivision to
 209.14 read:

209.15 Subd. 2a. **Uniform modification of a health plan.** (a) A health carrier may modify the
 209.16 health plan for a product, as defined under Code of Federal Regulations, title 45, section
 209.17 144.103, offered to an individual in the individual market, at the time of coverage renewal
 209.18 if the modification is effective uniformly for all individuals with that product.

209.19 (b) For purposes of paragraph (a), modifications made uniformly and solely pursuant to
 209.20 applicable federal or state requirements are considered a uniform modification of coverage
 209.21 if:

209.22 (1) the modification is made within a reasonable time period after the imposition or
 209.23 modification of the federal or state requirement; and

209.24 (2) the modification is directly related to the imposition or modification of the federal
 209.25 or state requirement.

209.26 (c) Other types of modifications made uniformly are considered a uniform modification
 209.27 of coverage if the health plan for the product in the individual market meets all of the
 209.28 following criteria:

209.29 (1) the product is offered by the same health carrier;

210.1 (2) the product is offered as the same product network type which includes, but is not
 210.2 limited to, a health maintenance organization, preferred provider organization, exclusive
 210.3 provider organization, point of service, or indemnity;

210.4 (3) the product continues to cover at least a majority of the same service area;

210.5 (4) within the product, each health plan has the same cost-sharing structure as before
 210.6 the modification, except for any variation in cost sharing solely related to changes in cost
 210.7 and utilization of medical care, or to maintain the same metal level, as defined under section
 210.8 62K.06, subdivision 4; and

210.9 (5) the product provides the same covered benefits, except for any changes in benefits
 210.10 that cumulatively impact the plan-adjusted index rate as defined under Code of Federal
 210.11 Regulations, title 45, section 156.80(d)(2), for any health plan within the product within an
 210.12 allowable variation of plus or minus two percentage points, not including changes pursuant
 210.13 to applicable federal or state requirements.

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

210.15 Sec. 6. Minnesota Statutes 2016, section 62A.65, subdivision 5, is amended to read:

210.16 Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or
 210.17 after January 1, 2014, no individual health plan may be offered, sold, issued, or renewed,
 210.18 to a Minnesota resident that contains a preexisting condition limitation, preexisting condition
 210.19 exclusion, or exclusionary rider. An individual age 19 or older may be subjected to an
 210.20 18-month preexisting condition limitation during plan years beginning prior to January 1,
 210.21 2014, unless the individual has maintained continuous coverage as defined in section 62L.02.
 210.22 The individual must not be subjected to an exclusionary rider. During plan years beginning
 210.23 prior to January 1, 2014, an individual who is age 19 or older and who has maintained
 210.24 continuous coverage may be subjected to a onetime preexisting condition limitation of up
 210.25 to 12 months, with credit for time covered under qualifying coverage as defined in section
 210.26 62L.02, at the time that the individual first is covered under an individual health plan by
 210.27 any health carrier. Credit must be given for all qualifying coverage with respect to all
 210.28 preexisting conditions, regardless of whether the conditions were preexisting with respect
 210.29 to any previous qualifying coverage. The individual must not be subjected to an exclusionary
 210.30 rider. Thereafter, the individual who is age 19 or older must not be subject to any preexisting
 210.31 condition limitation, preexisting condition exclusion, or exclusionary rider under an individual
 210.32 health plan by any health carrier, except an unexpired portion of a limitation under prior
 210.33 coverage, so long as the individual maintains continuous coverage as defined in section
 210.34 62L.02. The prohibition on preexisting condition limitations for children age 18 or under

211.1 does not apply to individual health plans that are grandfathered plans. The prohibition on
211.2 preexisting condition limitations for adults age 19 and over beginning for plan years on or
211.3 after January 1, 2014, does not apply to individual health plans that are grandfathered plans.

211.4 (b) A health carrier must offer an individual health plan to any individual previously
211.5 covered under a group health plan issued by that health carrier, regardless of the size of the
211.6 group, so long as the individual maintained continuous coverage as defined in section
211.7 62L.02. If the individual has available any continuation coverage provided under sections
211.8 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or
211.9 62D.105, or continuation coverage provided under federal law, the health carrier need not
211.10 offer coverage under this paragraph until the individual has exhausted the continuation
211.11 coverage. The offer must not be subject to underwriting, except as permitted under this
211.12 paragraph. A health plan issued under this paragraph must be a qualified plan as defined in
211.13 section 62E.02 and must not contain any preexisting condition limitation, preexisting
211.14 condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion
211.15 under the previous coverage. The individual health plan must cover pregnancy on the same
211.16 basis as any other covered illness under the individual health plan. The offer of coverage
211.17 by the health carrier must inform the individual that the coverage, including what is covered
211.18 and the health care providers from whom covered care may be obtained, may not be the
211.19 same as the individual's coverage under the group health plan. The offer of coverage by the
211.20 health carrier must also inform the individual that the individual, if a Minnesota resident,
211.21 may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii)
211.22 the Minnesota Comprehensive Health Association, without a preexisting condition limitation,
211.23 and must provide the telephone number used by that association for enrollment purposes.
211.24 The initial premium rate for the individual health plan must comply with subdivision 3. The
211.25 premium rate upon renewal must comply with subdivision 2. In no event shall the premium
211.26 rate exceed 100 percent of the premium charged for comparable individual coverage by the
211.27 Minnesota Comprehensive Health Association, and the premium rate must be less than that
211.28 amount if necessary to otherwise comply with this section. Coverage issued under this
211.29 paragraph must provide that it cannot be canceled or nonrenewed as a result of the health
211.30 carrier's subsequent decision to leave the individual, small employer, or other group market.
211.31 Section 72A.20, subdivision 28, applies to this paragraph. For plan years beginning on or
211.32 after January 1, 2017, a health carrier is not required to offer coverage under this paragraph.

211.33 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
211.34 renewed on or after January 1, 2018.

212.1 Sec. 7. Minnesota Statutes 2016, section 62D.105, subdivision 1, is amended to read:

212.2 Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to
 212.3 covering the enrollee also provides coverage to the ~~spouse and~~ dependent children to the
 212.4 limiting age as defined in section 62Q.01, subdivision 2a, of the enrollee and spouse who
 212.5 was covered on the day before entry of a valid decree of dissolution shall: (1) permit the
 212.6 spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision
 212.7 2a, to elect to continue coverage when the enrollee becomes enrolled for benefits under title
 212.8 XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to
 212.9 continue coverage when they cease to be dependent children to the limiting age as defined
 212.10 in section 62Q.01, subdivision 2a, under the generally applicable requirement of the plan.

212.11 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 212.12 renewed on or after January 1, 2018.

212.13 Sec. 8. Minnesota Statutes 2016, section 62D.105, subdivision 2, is amended to read:

212.14 Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be
 212.15 continued until the earlier of the following dates:

212.16 (1) the date coverage would otherwise terminate under the contract;

212.17 (2) 36 months after continuation by the spouse or dependent was elected; or

212.18 (3) the date the spouse or dependent children become covered under another group health
 212.19 plan or Medicare.

212.20 If coverage is provided under a group policy, any required fees for the coverage shall
 212.21 be paid by the enrollee on a monthly basis to the group contract holder for remittance to the
 212.22 health maintenance organization. In no event shall the fee charged exceed 102 percent of
 212.23 the cost to the plan for such coverage for other similarly situated spouse and dependent
 212.24 children to the limiting age as defined in section 62Q.01, subdivision 2a, to whom subdivision
 212.25 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

212.26 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 212.27 renewed on or after January 1, 2018.

212.28 Sec. 9. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

212.29 Subd. 11. ~~Essential health benefits package~~ **Affordable Care Act compliant plans.**
 212.30 ~~For individual or small group health plans that include the essential health benefits package~~
 212.31 ~~and are~~ any policy of accident and health insurance subject to the requirements of the

213.1 Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold,
 213.2 issued, or renewed on or after January 1, ~~2014~~ 2018, the requirements of this section do not
 213.3 apply.

213.4 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 213.5 renewed on or after January 1, 2018.

213.6 Sec. 10. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

213.7 Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for
 213.8 certification of a plan of health coverage as a qualified plan or a qualified Medicare
 213.9 supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall
 213.10 make a determination within 90 days as to whether the plan is qualified. All plans of health
 213.11 coverage, except Medicare supplement policies, shall be labeled as "qualified" or
 213.12 "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified
 213.13 plans shall indicate whether they are number one, two, or three coverage plans. For any
 213.14 policy of accident and health insurance subject to the requirements of the Affordable Care
 213.15 Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or
 213.16 renewed on or after January 1, 2018, the requirements of this section do not apply.

213.17 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 213.18 renewed on or after January 1, 2018.

213.19 Sec. 11. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to
 213.20 read:

213.21 Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health
 213.22 insurance subject to the requirements of the Affordable Care Act, as defined under section
 213.23 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1,
 213.24 2018, the requirements of this section do not apply.

213.25 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 213.26 renewed on or after January 1, 2018.

213.27 Sec. 12. Minnesota Statutes 2016, section 62Q.18, subdivision 7, is amended to read:

213.28 Subd. 7. **Portability of coverage.** Effective July 1, 1994, no health plan company shall
 213.29 offer, sell, issue, or renew any group health plan that does not, with respect to individuals
 213.30 who maintain continuous coverage and who qualify under the group's eligibility requirements:

213.31 (1) make coverage available on a guaranteed issue basis;

214.1 (2) give full credit for previous continuous coverage against any applicable preexisting
214.2 condition limitation or preexisting condition exclusion; and

214.3 (3) with respect to a group health plan offered, sold, issued, or renewed to a large
214.4 employer, impose preexisting condition limitations or preexisting condition exclusions
214.5 except to the extent that would be permitted under chapter 62L if the group sponsor were
214.6 a small employer as defined in section 62L.02, subdivision 26.

214.7 To the extent that this subdivision conflicts with chapter 62L, chapter 62L governs,
214.8 regardless of whether the group sponsor is a small employer as defined in section 62L.02,
214.9 except that for group health plans issued to groups that are not small employers, this
214.10 subdivision's requirement that the individual have maintained continuous coverage applies.
214.11 An individual who has maintained continuous coverage, but would be considered a late
214.12 entrant under chapter 62L, may be treated as a late entrant in the same manner under this
214.13 subdivision as permitted under chapter 62L. For plan years beginning on or after January
214.14 1, 2017, a health plan company is no longer required to offer coverage under this subdivision.

214.15 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
214.16 renewed on or after January 1, 2018.

214.17 Sec. 13. **[62Q.575] ACCESS TO PRIMARY CARE PROVIDERS.**

214.18 **Subdivision 1. Provider network.** (a) No health plan company offering an individual
214.19 health plan that is not a grandfathered plan shall deny a primary care provider the right to
214.20 contract with the health plan company as an in-network provider if the primary care provider
214.21 meets one of the following criteria:

214.22 (1) is certified as a health care home by the commissioner of health under section
214.23 256B.0751. To remain eligible for in-network status under this section, the primary care
214.24 provider must maintain certification as a health care home; or

214.25 (2) is in the process of becoming certified as a health care home under section 256B.0751.
214.26 To remain eligible for in-network status under this subdivision, the primary care provider
214.27 must complete the certification process within six months to remain an in-network provider.

214.28 (b) A health plan company may require the primary care provider to meet reasonable
214.29 data, utilization review, and quality assurance requirements on the same basis as other
214.30 in-network providers.

214.31 (c) The primary care provider must agree to serve all enrollees of the health care company
214.32 who select or designate the primary care provider, if designation is required.

215.1 (d) The primary care provider and health plan company may negotiate the payment rate
215.2 for covered services provided by the primary care provider. The rate must not be less than
215.3 the rate paid by the health plan company to the provider under a different category of
215.4 coverage or health product, or other arrangement within a category of coverage.

215.5 Subd. 2. **Cost-sharing or other conditions.** No health plan company shall impose a
215.6 co-payment, fee, or other cost-sharing requirement for selecting or designating a primary
215.7 care provider of the enrollee's choosing or impose other conditions that limit the enrollee's
215.8 ability to utilize a primary care provider of the enrollee's choosing, unless the health plan
215.9 company imposes the same cost-sharing requirements, fees, conditions, or limits upon an
215.10 enrollee's selection or designation of any of the health plan company's in-network primary
215.11 care providers.

215.12 Subd. 3. **Care coordination.** (a) As part of the provider contract with primary care
215.13 providers that are certified health care homes, the contract must include a care coordination
215.14 payment for providing care coordination services. The care coordination payment under
215.15 this subdivision must be a per enrollee, per month payment and must be in addition to the
215.16 payment rate for the covered services provided by the primary care provider.

215.17 (b) The care coordination payment may vary based on care complexity, but must at least
215.18 be equal to the payment amounts established under section 256B.0753.

215.19 (c) The health plan company shall not impose a co-payment, fee, or other cost-sharing
215.20 requirement for care coordination services.

215.21 Subd. 4. **Notice.** The health plan company shall provide notice to enrollees of the
215.22 provisions of this section.

215.23 Subd. 5. **Definition.** For purposes of this section, "primary care provider" means a
215.24 physician licensed under chapter 147 or an advanced practice registered nurse licensed
215.25 under chapter 148 who specializes in the practice of family medicine, general internal
215.26 medicine, obstetrics and gynecology, or general pediatrics; or a health care clinic that
215.27 specializes in the above-mentioned areas and utilizes a primary care team that includes
215.28 physicians, physician assistants, or advanced practice registered nurses.

215.29 Subd. 6. **Limitations.** (a) This section does not apply to enrollees who are enrolled in
215.30 a public health care program under chapter 256B or 256L, or the Minnesota restricted
215.31 recipient program pursuant to Minnesota Rules, part 9505.2238.

215.32 (b) This section does not waive any exclusions of coverage under the terms and conditions
215.33 of the enrollee's health plan.

216.1 (c) This section only applies to individual health plans.

216.2 Subd. 7. **Enforcement.** The commissioner of health shall enforce this section.

216.3 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to any
 216.4 individual health plan offered, sold, issued, or renewed on or after that date.

216.5 Sec. 14. [62Q.678] NETWORK OFFERINGS.

216.6 (a) In counties where a health plan company actively markets an individual health plan,
 216.7 the health plan company must offer, in those counties, at least one individual health plan
 216.8 with a provider network that includes in-network access to more than a single health care
 216.9 provider system or a health plan that includes more than one primary care location in a
 216.10 county. This section is applicable only for the plan year in which the health plan company
 216.11 actively markets an individual health plan.

216.12 (b) The commissioner of health shall enforce this section.

216.13 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to any health
 216.14 plan offered, sold, issued, or renewed on or after that date.

216.15 Sec. 15. Minnesota Statutes 2016, section 317A.811, subdivision 1, is amended to read:

216.16 Subdivision 1. **When required.** (a) Except as provided in subdivision 6, the following
 216.17 corporations shall notify the attorney general of their intent to dissolve, merge, or consolidate,
 216.18 or to transfer all or substantially all of their assets:

216.19 (1) a corporation that holds assets for a charitable purpose as defined in section 501B.35,
 216.20 subdivision 2; ~~or~~

216.21 (2) a health maintenance organization operating under chapter 62D;

216.22 (3) a service plan corporation operating under chapter 62C; or

216.23 ~~(2)~~ (4) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code
 216.24 of 1986, or any successor section.

216.25 (b) The notice must include:

216.26 (1) the purpose of the corporation that is giving the notice;

216.27 (2) a list of assets owned or held by the corporation for charitable purposes;

216.28 (3) a description of restricted assets and purposes for which the assets were received;

216.29 (4) a description of debts, obligations, and liabilities of the corporation;

217.1 (5) a description of tangible assets being converted to cash and the manner in which
217.2 they will be sold;

217.3 (6) anticipated expenses of the transaction, including attorney fees;

217.4 (7) a list of persons to whom assets will be transferred, if known;

217.5 (8) the purposes of persons receiving the assets; and

217.6 (9) the terms, conditions, or restrictions, if any, to be imposed on the transferred assets.

217.7 The notice must be signed on behalf of the corporation by an authorized person.

217.8 Sec. 16. Minnesota Statutes 2016, section 317A.811, is amended by adding a subdivision
217.9 to read:

217.10 Subd. 1a. **Nonprofit health care entity; notice and approval required.** A corporation
217.11 that is a health maintenance organization or a service plan corporation is subject to notice
217.12 and approval requirements for certain transactions under section 317A.814.

217.13 Sec. 17. **[317A.814] NONPROFIT HEALTH CARE ENTITY CONVERSIONS.**

217.14 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

217.15 (b) "Commissioner" means the commissioner of commerce if the nonprofit health care
217.16 entity at issue is a service plan corporation operating under chapter 62C, and the
217.17 commissioner of health if the nonprofit health care entity at issue is a health maintenance
217.18 organization operating under chapter 62D.

217.19 (c) "Conversion benefit entity" means a foundation, corporation, limited liability
217.20 company, trust, partnership, or other entity that receives public benefit assets, or their value,
217.21 in connection with a conversion transaction.

217.22 (d) "Conversion transaction" or "transaction" means a transaction in which a nonprofit
217.23 health care entity merges, consolidates, converts, or transfers all or a substantial portion of
217.24 its assets to an entity that is not a nonprofit corporation organized under this chapter that is
217.25 also exempt under United States Code, title 26, section 501(c)(3). The substitution of a new
217.26 corporate member that transfers the control, responsibility for, or governance of a nonprofit
217.27 health care entity is also considered a transaction for purposes of this section.

217.28 (e) "Family member" means a spouse, parent, or child or other legal dependent.

217.29 (f) "Nonprofit health care entity" means a service plan corporation operating under
217.30 chapter 62C and a health maintenance organization operating under chapter 62D.

218.1 (g) "Public benefit assets" means the entirety of a nonprofit health care entity's assets,
218.2 whether tangible or intangible.

218.3 (h) "Related organization" has the meaning given in section 317A.011.

218.4 Subd. 2. **Private inurement.** A nonprofit health care entity must not enter into a
218.5 conversion transaction if a person who has been an officer, director, or other executive of
218.6 the nonprofit health care entity, or of a related organization, or a family member of that
218.7 person:

218.8 (1) has or will receive any compensation or other financial benefit, directly or indirectly,
218.9 in connection with the conversion transaction;

218.10 (2) has held or will hold, regardless of whether guaranteed or contingent, an ownership
218.11 stake, stock, securities, investment, or other financial interest in, or receive any type of
218.12 compensation or other financial benefit from, any entity to which the nonprofit health care
218.13 entity transfers public benefit assets in connection with a conversion transaction; or

218.14 (3) has held or will hold, regardless of whether guaranteed or contingent, an ownership
218.15 stake, stock, securities, investment, or other financial interest in, or receive any type of
218.16 compensation or other financial benefit from, any entity that has or will have a business
218.17 relationship with any entity to which the nonprofit health care entity transfers public benefit
218.18 assets in connection with a conversion transaction.

218.19 Subd. 3. **Attorney general notice and approval required.** (a) Before entering into a
218.20 conversion transaction, the nonprofit health care entity must notify the attorney general as
218.21 specified under section 317A.811, subdivision 1. The notice required by this subdivision
218.22 also must include an itemization of the nonprofit health care entity's public benefit assets
218.23 and the valuation that the entity attributes to those assets, a proposed plan for distribution
218.24 of the value of those assets to a conversion benefit entity that meets the requirements of
218.25 subdivision 5, and other information from the health maintenance organization or the
218.26 proposed conversion benefit entity that the attorney general reasonably considers necessary
218.27 for review of the proposed transaction.

218.28 (b) A copy of the notice and other information required under this subdivision must be
218.29 given to the commissioner.

218.30 Subd. 4. **Review elements.** (a) The attorney general may approve, conditionally approve,
218.31 or not approve a conversion transaction under this section. In making a decision whether
218.32 to approve, conditionally approve, or not approve a proposed transaction, the attorney

219.1 general, in consultation with the commissioner, shall consider any factors the attorney

219.2 general considers relevant, including whether:

219.3 (1) the proposed transaction complies with this chapter and chapter 501B and other
219.4 applicable laws;

219.5 (2) the proposed transaction involves or constitutes a breach of charitable trust;

219.6 (3) the nonprofit health care entity will receive full and fair value for its public benefit
219.7 assets;

219.8 (4) the full and fair value of the public benefit assets to be transferred has been
219.9 manipulated in a manner that causes or has caused the value of the assets to decrease;

219.10 (5) the proceeds of the proposed transaction will be used consistent with the public
219.11 benefit for which the assets are held by the nonprofit health care entity;

219.12 (6) the proposed transaction will result in a breach of fiduciary duty, as determined by
219.13 the attorney general, including whether:

219.14 (i) conflicts of interest exist related to payments to or benefits conferred upon officers,
219.15 directors, board members, and executives of the nonprofit health care entity or a related
219.16 organization;

219.17 (ii) the nonprofit health care entity's board of directors exercised reasonable care and
219.18 due diligence in deciding to pursue the transaction, in selecting the entity with which to
219.19 pursue the transaction, and in negotiating the terms and conditions of the transaction; and

219.20 (iii) the nonprofit health care entity's board of directors considered all reasonably viable
219.21 alternatives, including any competing offers for its public benefit assets, or alternative
219.22 transactions;

219.23 (7) the transaction will result in private inurement to any person, including owners,
219.24 stakeholders, or directors, officers, or key staff of the nonprofit health care entity or entity
219.25 to which the nonprofit health care entity proposes to transfer public benefit assets;

219.26 (8) the conversion benefit entity meets the requirements of subdivision 5; and

219.27 (9) the attorney general and the commissioner have been provided with sufficient
219.28 information by the nonprofit health care entity to adequately evaluate the proposed transaction
219.29 and the effects on the public, provided the attorney general or the commissioner has notified
219.30 the nonprofit health care entity or the proposed conversion benefit entity of any inadequacy
219.31 of the information and has provided a reasonable opportunity to remedy that inadequacy.

220.1 In addition, the attorney general shall consider the public comments received regarding
220.2 the proposed conversion transaction and the proposed transaction's likely effect on the
220.3 availability, accessibility, and affordability of health care services to the public.

220.4 (b) The attorney general must consult with the commissioner in making a decision
220.5 whether to approve or disapprove a transaction.

220.6 Subd. 5. **Conversion benefit entity requirements.** (a) A conversion benefit entity must
220.7 be an existing or new domestic nonprofit corporation organized under this chapter and also
220.8 be exempt under United States Code, title 26, section 501(c)(3).

220.9 (b) The conversion benefit entity must be completely independent of any influence or
220.10 control by the nonprofit health care entity and related organizations, all entities to which
220.11 the nonprofit health care entity transfers any public benefit assets in connection with a
220.12 conversion transaction, and the directors, officers, and other executives of those organizations
220.13 or entities.

220.14 (c) The conversion benefit entity must have in place procedures and policies to prohibit
220.15 conflicts of interest, including but not limited to prohibiting conflicts of interests relating
220.16 to any grant-making activities that may benefit:

220.17 (1) the directors, officers, or other executives of the conversion benefit entity;

220.18 (2) any entity to which the nonprofit health care entity transfers any public benefit assets
220.19 in connection with a conversion transaction; or

220.20 (3) any directors, officers, or other executives of any entity to which the nonprofit health
220.21 care entity transfers any public benefit assets in connection with a conversion transaction.

220.22 (d) The charitable purpose and grant-making functions of the conversion benefit entity
220.23 must be dedicated to meeting the health care needs of the people of this state.

220.24 Subd. 6. **Public comment.** Before issuing a decision under subdivision 7, the attorney
220.25 general may solicit public comment regarding the proposed conversion transaction. The
220.26 attorney general may hold one or more public meetings or solicit written or electronic
220.27 correspondence. If a meeting is held, notice of the meeting must be published in a qualified
220.28 newspaper of general circulation in this state at least seven days before the meeting.

220.29 Subd. 7. **Period for approval or disapproval; extension.** (a) Within 150 days of
220.30 receiving notice of a proposed transaction, the attorney general shall notify the nonprofit
220.31 health care entity in writing of its decision to approve, conditionally approve, or disapprove
220.32 the transaction. If the transaction is not approved, the notice must include the reason for the
220.33 decision. If the transaction is conditionally approved, the notice must specify the conditions

221.1 that must be met. The attorney general may extend this period for an additional 90 days if
221.2 necessary to obtain additional information.

221.3 (b) The time periods under this subdivision are suspended during the time when a request
221.4 from the attorney general for additional information is outstanding.

221.5 Subd. 8. **Transfer of value of assets required.** If a proposed conversion transaction is
221.6 approved or conditionally approved by the attorney general, the nonprofit health care entity
221.7 shall transfer the entirety of the full and fair value of its public benefit assets to one or more
221.8 conversion benefit entities as part of the transaction.

221.9 Subd. 9. **Assessment of costs.** The nonprofit health care entity or the conversion benefit
221.10 entity must reimburse the attorney general or a state agency for all reasonable and actual
221.11 costs incurred by the attorney general or a state agency in reviewing a proposed conversion
221.12 transaction, including attorney fees at the billing rate used by the attorney general for state
221.13 agencies and the costs for retention of actuarial, valuation, or other experts or consultants,
221.14 and administrative costs.

221.15 Subd. 10. **Annual report by conversion benefit entity.** A conversion benefit entity
221.16 must submit an annual report to the attorney general that contains a detailed description of
221.17 its charitable activities related to the use of the public benefit assets received under a
221.18 transaction that is approved under this section.

221.19 Subd. 11. **Penalties; remedies.** A conversion transaction entered into in violation of
221.20 this section is null and void. The attorney general is authorized to bring an action to unwind
221.21 a conversion transaction entered into in violation of this section and to recover the amount
221.22 of any private inurement received or held in violation of subdivision 2. In addition to this
221.23 recovery, the officers, directors, and other executives of each entity that is a party to and
221.24 materially participated in a conversion transaction entered into in violation of this section
221.25 may be subject to a civil penalty of up to the greater of either the entirety of any financial
221.26 benefit each one derived from the transaction, or \$1,000,000, as determined by the court.
221.27 The attorney general is authorized to enforce this section pursuant to section 8.31.

221.28 Subd. 12. **Relation to other law.** (a) This section is in addition to, and does not affect
221.29 or limit any power, remedy, or responsibility of a health maintenance organization, service
221.30 plan corporation, a conversion benefit entity, the attorney general, or the commissioner
221.31 under this chapter, chapter 62C, 62D, 501B, or other law.

221.32 (b) Nothing in this section authorizes a nonprofit health care entity to enter into a
221.33 conversion transaction not otherwise permitted under this chapter.

222.1 Sec. 18. Laws 2017, chapter 2, article 1, section 1, subdivision 3, is amended to read:

222.2 Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

222.3 (1) is not receiving a an advanced premium tax credit under Code of Federal Regulations,
222.4 title 26, section 1.36B-2, as of the date their coverage is effectuated in a month in which
222.5 their coverage is effective;

222.6 (2) is not enrolled in public program coverage under Minnesota Statutes, section
222.7 256B.055, or 256L.04; and

222.8 (3) purchased an individual health plan from a health carrier in the individual market.

222.9 Sec. 19. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

222.10 Subd. 4. **Data practices.** (a) The definitions in Minnesota Statutes, section 13.02, apply
222.11 to this subdivision.

222.12 (b) Government data on an enrollee or health carrier under this section are private data
222.13 on individuals or nonpublic data, except that the total reimbursement requested by a health
222.14 carrier and the total state payment to the health carrier are public data.

222.15 (c) Notwithstanding Minnesota Statutes, section 138.17, not public government data on
222.16 an enrollee or health carrier collected under this section must be destroyed by June 30, 2018,
222.17 or upon completion by the legislative auditor of the audits required by section 3, whichever
222.18 is later, except to the extent the legislative auditor maintains data for a longer period of time
222.19 in order to comply with generally accepted government auditing standards.

222.20 Sec. 20. Laws 2017, chapter 2, article 1, section 2, is amended by adding a subdivision to
222.21 read:

222.22 Subd. 5. **Data sharing.** (a) Notwithstanding any law to the contrary, the commissioner
222.23 of human services and the executive director of MNsure must disclose to the commissioner
222.24 of management and budget data on public program coverage enrollment under Minnesota
222.25 Statutes, sections 256B.055 and 256L.04, data on an enrollee's receipt of an advanced
222.26 premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2.

222.27 (b) Notwithstanding any law to the contrary, the commissioner of management and
222.28 budget must disclose data to health carriers on enrollees' enrollment in public program
222.29 coverage under Minnesota Statutes, section 256B.055 or 256L.04, to the extent that the
222.30 commissioner determines the disclosure is necessary for purposes of determining eligibility
222.31 for the premium subsidy program authorized by this act.

223.1 (c) Data disclosed under this subdivision may be used only for the purpose of
223.2 administration of the premium subsidy program under this act and may not be further
223.3 disclosed to any other person, except as otherwise provided by law.

223.4 Sec. 21. Laws 2017, chapter 2, article 1, section 3, is amended to read:

223.5 **Sec. 3. AUDITS.**

223.6 (a) The legislative auditor shall conduct audits of the health carriers' supporting data, as
223.7 prescribed by the commissioner, to determine whether payments align with criteria
223.8 established in sections 1 and 2. The commissioner of human services shall provide data as
223.9 necessary to the legislative auditor to complete the audit. The commissioner shall withhold
223.10 or charge back payments to the health carriers to the extent they do not align with the criteria
223.11 established in sections 1 and 2, as determined by the audit.

223.12 (b) The legislative auditor shall audit the extent to which health carriers provided premium
223.13 subsidies to persons meeting the residency and other eligibility requirements specified in
223.14 section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount
223.15 of premium subsidies provided by each health carrier to persons not eligible for a premium
223.16 subsidy. The commissioner, in consultation with the commissioners of commerce ~~and~~₂
223.17 health, and human services shall develop and implement a process to recover from health
223.18 carriers the amount of premium subsidies received for enrollees determined to be ineligible
223.19 for premium subsidies by the legislative auditor. The legislative auditor, when conducting
223.20 the required audit, and the commissioner, when determining the amount of premium subsidy
223.21 to be recovered, may take into account the extent to which a health carrier makes use of the
223.22 Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision
223.23 1.

223.24 Sec. 22. Laws 2017, chapter 2, article 1, section 5, is amended to read:

223.25 **Sec. 5. SUNSET.**

223.26 This article ~~sunset~~s ~~June 30~~, other than section 2, subdivision 5, and section 3, sunsets
223.27 August 31, 2018.

223.28 Sec. 23. Laws 2017, chapter 2, article 1, section 7, is amended to read:

223.29 **Sec. 7. APPROPRIATIONS.**

224.1 (a) \$311,788,000 in fiscal year 2017 is appropriated from the general fund to the
224.2 commissioner of management and budget for premium assistance under section 2. This
224.3 appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

224.4 (b) \$157,000 in fiscal year 2017 is appropriated from the general fund to the legislative
224.5 auditor for purposes of section 3. This appropriation is onetime.

224.6 (c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018,
224.7 shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the
224.8 budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

224.9 Sec. 24. Laws 2017, chapter 2, article 2, section 13, is amended to read:

224.10 Sec. 13. **62Q.556 UNAUTHORIZED PROVIDER SERVICES.**

224.11 Subdivision 1. **Unauthorized provider services.** (a) Except as provided in paragraph
224.12 (c), unauthorized provider services occur when an enrollee receives services:

224.13 (1) from a nonparticipating provider at a participating hospital or ambulatory surgical
224.14 center, when the services are rendered:

224.15 (i) due to the unavailability of a participating provider;

224.16 (ii) by a nonparticipating provider without the enrollee's knowledge; or

224.17 (iii) due to the need for unforeseen services arising at the time the services are being
224.18 rendered; or

224.19 (2) from a participating provider that sends a specimen taken from the enrollee in the
224.20 participating provider's practice setting to a nonparticipating laboratory, pathologist, or other
224.21 medical testing facility.

224.22 (b) Unauthorized provider services do not include emergency services as defined in
224.23 section 62Q.55, subdivision 3.

224.24 (c) The services described in paragraph (a), clause (2), are not unauthorized provider
224.25 services if the enrollee gives advance written consent to the provider acknowledging that
224.26 the use of a provider, or the services to be rendered, may result in costs not covered by the
224.27 health plan.

224.28 Subd. 2. **Prohibition.** (a) An enrollee's financial responsibility for the unauthorized
224.29 provider services shall be the same cost-sharing requirements, including co-payments,
224.30 deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable
224.31 to services received by the enrollee from a participating provider. A health plan company

225.1 must apply any enrollee cost sharing requirements, including co-payments, deductibles, and
 225.2 coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit
 225.3 to the same extent payments to a participating provider would be applied.

225.4 (b) A health plan company must attempt to negotiate the reimbursement, less any
 225.5 applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services
 225.6 with the nonparticipating provider. If a health plan company's and nonparticipating provider's
 225.7 attempts to negotiate reimbursement for the health care services do not result in a resolution,
 225.8 the health plan company or provider may elect to refer the matter for binding arbitration,
 225.9 chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by
 225.10 both parties prior to engaging an arbitrator in accordance with this section. The cost of
 225.11 arbitration must be shared equally between the parties.

225.12 (c) The commissioner of health, in consultation with the commissioner of the Bureau
 225.13 of Mediation Services, must develop a list of professionals qualified in arbitration, for the
 225.14 purpose of resolving disputes between a health plan company and nonparticipating provider
 225.15 arising from the payment for unauthorized provider services. The commissioner of health
 225.16 shall publish the list on the department of health's Web Site, and update the list as appropriate.

225.17 (d) The arbitrator must consider relevant information, including the health plan company's
 225.18 payments to other nonparticipating providers for the same services, the circumstances and
 225.19 complexity of the particular case, and the usual and customary rate for the service based on
 225.20 information available in a database in a national, independent, not-for-profit corporation,
 225.21 and similar fees received by the provider for the same services from other health plans in
 225.22 which the provider is nonparticipating, in reaching a decision.

225.23 Subd. 3. **Scope.** This section does not apply to services provided under chapter 256B or
 225.24 256L.

225.25 Sec. 25. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

225.26 **EFFECTIVE DATE.** This section is effective ~~90 days following final enactment~~ January
 225.27 1, 2019, and applies to provider services provided on or after that date.

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

225.29

ARTICLE 6

225.30

DIRECT CARE AND TREATMENT

225.31 Section 1. Minnesota Statutes 2016, section 253B.10, subdivision 1, is amended to read:

226.1 Subdivision 1. **Administrative requirements.** (a) When a person is committed, the
 226.2 court shall issue a warrant or an order committing the patient to the custody of the head of
 226.3 the treatment facility. The warrant or order shall state that the patient meets the statutory
 226.4 criteria for civil commitment.

226.5 (b) The commissioner shall prioritize patients being admitted from jail or a correctional
 226.6 institution who are:

226.7 (1) ordered confined in a state hospital for an examination under Minnesota Rules of
 226.8 Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

226.9 (2) under civil commitment for competency treatment and continuing supervision under
 226.10 Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

226.11 (3) found not guilty by reason of mental illness under Minnesota Rules of Criminal
 226.12 Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be
 226.13 detained in a state hospital or other facility pending completion of the civil commitment
 226.14 proceedings; or

226.15 (4) committed under this chapter to the commissioner after dismissal of the patient's
 226.16 criminal charges.

226.17 Patients described in this paragraph must be admitted to a service operated by the
 226.18 commissioner within 48 hours. Regardless of when the 48-hour time period expires, a
 226.19 regional treatment center is not required to admit a patient after 12:00 p.m. on Friday and
 226.20 before 8:00 a.m. on Monday. The commitment must be ordered by the court as provided in
 226.21 section 253B.09, subdivision 1, paragraph (c).

226.22 (c) Upon the arrival of a patient at the designated treatment facility, the head of the
 226.23 facility shall retain the duplicate of the warrant and endorse receipt upon the original warrant
 226.24 or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed
 226.25 in the court of commitment. After arrival, the patient shall be under the control and custody
 226.26 of the head of the treatment facility.

226.27 (d) Copies of the petition for commitment, the court's findings of fact and conclusions
 226.28 of law, the court order committing the patient, the report of the examiners, and the prepetition
 226.29 report shall be provided promptly to the treatment facility.

226.30 Sec. 2. Minnesota Statutes 2016, section 253B.22, subdivision 1, is amended to read:

226.31 Subdivision 1. **Establishment.** The commissioner shall establish a review board ~~of three~~
 226.32 ~~or more persons for each regional center~~ to review the admission and retention of its patients

227.1 receiving services under this chapter. The review board shall be comprised of two members
 227.2 and one chair. Each board member shall be selected and appointed by the commissioner.
 227.3 The appointed members shall be limited to one term of no more than three years and no
 227.4 board member can serve more than three consecutive three-year terms. One member shall
 227.5 be qualified in the diagnosis of mental illness, developmental disability, or chemical
 227.6 dependency, and one member shall be an attorney. The commissioner may, upon written
 227.7 request from the appropriate federal authority, establish a review panel for any federal
 227.8 treatment facility within the state to review the admission and retention of patients
 227.9 hospitalized under this chapter. For any review board established for a federal treatment
 227.10 facility, one of the persons appointed by the commissioner shall be the commissioner of
 227.11 veterans affairs or the commissioner's designee.

227.12 Sec. 3. **REVIEW OF ALTERNATIVES TO STATE-OPERATED GROUP HOMES**
 227.13 **HOUSING ONE PERSON.**

227.14 The commissioner of human services shall review the potential for, and the viability of,
 227.15 alternatives to state-operated group homes housing one person. The intent is to create housing
 227.16 options for individuals who do not belong in an institutionalized setting, but need additional
 227.17 support before transitioning to a more independent community placement. The review shall
 227.18 include an analysis of existing housing settings operated by counties and private providers,
 227.19 as well as the potential for new housing settings, and determine the viability for use by
 227.20 state-operated services. The commissioner shall seek input from interested stakeholders as
 227.21 part of the review. An update, including alternatives identified, will be provided by the
 227.22 commissioner to the members of the legislative committees having jurisdiction over human
 227.23 services issues no later than January 15, 2018.

227.24 **ARTICLE 7**

227.25 **CHILDREN AND FAMILIES**

227.26 Section 1. Minnesota Statutes 2016, section 13.32, is amended by adding a subdivision
 227.27 to read:

227.28 Subd. 12. **Access by welfare system.** County personnel in the welfare system may
 227.29 request access to education data in order to coordinate services for a student or family. The
 227.30 request must be submitted to the chief administrative officer of the school and must include
 227.31 the basis for the request and a description of the information that is requested. The chief
 227.32 administrative officer must provide a copy of the request to the parent or legal guardian of
 227.33 the student who is the subject of the request, along with a form the parent or legal guardian

228.1 may execute to consent to the release of specified information to the requester. Education
228.2 data may be released under this subdivision only if the parent or legal guardian gives
228.3 informed consent to the release.

228.4 Sec. 2. Minnesota Statutes 2016, section 13.46, subdivision 1, is amended to read:

228.5 Subdivision 1. **Definitions.** As used in this section:

228.6 (a) "Individual" means an individual according to section 13.02, subdivision 8, but does
228.7 not include a vendor of services.

228.8 (b) "Program" includes all programs for which authority is vested in a component of the
228.9 welfare system according to statute or federal law, including, but not limited to, Native
228.10 American tribe programs that provide a service component of the welfare system, the aid
228.11 to families with dependent children program formerly codified in sections 256.72 to 256.87,
228.12 Minnesota family investment program, temporary assistance for needy families program,
228.13 medical assistance, general assistance, general assistance medical care formerly codified in
228.14 chapter 256D, child care assistance program, and child support collections.

228.15 (c) "Welfare system" includes the Department of Human Services, local social services
228.16 agencies, county welfare agencies, county public health agencies, county veteran services
228.17 agencies, county housing agencies, private licensing agencies, the public authority responsible
228.18 for child support enforcement, human services boards, community mental health center
228.19 boards, state hospitals, state nursing homes, the ombudsman for mental health and
228.20 developmental disabilities, Native American tribes to the extent a tribe provides a service
228.21 component of the welfare system, and persons, agencies, institutions, organizations, and
228.22 other entities under contract to any of the above agencies to the extent specified in the
228.23 contract.

228.24 (d) "Mental health data" means data on individual clients and patients of community
228.25 mental health centers, established under section 245.62, mental health divisions of counties
228.26 and other providers under contract to deliver mental health services, or the ombudsman for
228.27 mental health and developmental disabilities.

228.28 (e) "Fugitive felon" means a person who has been convicted of a felony and who has
228.29 escaped from confinement or violated the terms of probation or parole for that offense.

228.30 (f) "Private licensing agency" means an agency licensed by the commissioner of human
228.31 services under chapter 245A to perform the duties under section 245A.16.

229.1 Sec. 3. Minnesota Statutes 2016, section 13.46, subdivision 2, is amended to read:

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

229.4 (1) according to section 13.05;

229.5 (2) according to court order;

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

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

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

229.16 (6) to administer federal funds or programs;

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

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

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

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

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

230.5 (iii) to monitor and evaluate the Minnesota family investment program or the child care
230.6 assistance program by exchanging data on recipients and former recipients of food support,
230.7 cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter
230.8 119B, medical programs under chapter 256B or 256L, or a medical program formerly
230.9 codified under chapter 256D; and

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

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

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

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

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

230.32 (14) participant Social Security numbers and names collected by the telephone assistance
230.33 program may be disclosed to the Department of Revenue to conduct an electronic data

231.1 match with the property tax refund database to determine eligibility under section 237.70,
231.2 subdivision 4a;

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

231.6 (i) the participant:

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

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

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

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

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

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

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

231.25 (i) the member:

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

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

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

- 232.1 (ii) locating or apprehending the member is within the officer's official duties; and
- 232.2 (iii) the request is made in writing and in the proper exercise of the officer's official duty;
- 232.3 (19) the current address of a recipient of Minnesota family investment program, general
232.4 assistance, or food support may be disclosed to law enforcement officers who, in writing,
232.5 provide the name of the recipient and notify the agency that the recipient is a person required
232.6 to register under section 243.166, but is not residing at the address at which the recipient is
232.7 registered under section 243.166;
- 232.8 (20) certain information regarding child support obligors who are in arrears may be
232.9 made public according to section 518A.74;
- 232.10 (21) data on child support payments made by a child support obligor and data on the
232.11 distribution of those payments excluding identifying information on obligees may be
232.12 disclosed to all obligees to whom the obligor owes support, and data on the enforcement
232.13 actions undertaken by the public authority, the status of those actions, and data on the income
232.14 of the obligor or obligee may be disclosed to the other party;
- 232.15 (22) data in the work reporting system may be disclosed under section 256.998,
232.16 subdivision 7;
- 232.17 (23) to the Department of Education for the purpose of matching Department of Education
232.18 student data with public assistance data to determine students eligible for free and
232.19 reduced-price meals, meal supplements, and free milk according to United States Code,
232.20 title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state
232.21 funds that are distributed based on income of the student's family; and to verify receipt of
232.22 energy assistance for the telephone assistance plan;
- 232.23 (24) the current address and telephone number of program recipients and emergency
232.24 contacts may be released to the commissioner of health or a community health board as
232.25 defined in section 145A.02, subdivision 5, when the commissioner or community health
232.26 board has reason to believe that a program recipient is a disease case, carrier, suspect case,
232.27 or at risk of illness, and the data are necessary to locate the person;
- 232.28 (25) to other state agencies, statewide systems, and political subdivisions of this state,
232.29 including the attorney general, and agencies of other states, interstate information networks,
232.30 federal agencies, and other entities as required by federal regulation or law for the
232.31 administration of the child support enforcement program;

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

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

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

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

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

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

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

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

233.29 (b) Information on persons who have been treated for drug or alcohol abuse may only
233.30 be disclosed according to the requirements of Code of Federal Regulations, title 42, sections
233.31 2.1 to 2.67.

233.32 (c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16),
233.33 (17), or (18), or paragraph (b), are investigative data and are confidential or protected

234.1 nonpublic while the investigation is active. The data are private after the investigation
234.2 becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

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

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

234.7 Sec. 4. Minnesota Statutes 2016, section 13.84, subdivision 5, is amended to read:

234.8 Subd. 5. **Disclosure.** Private or confidential court services data shall not be disclosed
234.9 except:

234.10 (a) pursuant to section 13.05;

234.11 (b) pursuant to a statute specifically authorizing disclosure of court services data;

234.12 (c) with the written permission of the source of confidential data;

234.13 (d) to the court services department, parole or probation authority or state or local
234.14 correctional agency or facility having statutorily granted supervision over the individual
234.15 subject of the data, or to county personnel within the welfare system;

234.16 (e) pursuant to subdivision 6;

234.17 (f) pursuant to a valid court order; or

234.18 (g) pursuant to section 611A.06, subdivision 3a.

234.19 Sec. 5. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision
234.20 to read:

234.21 Subd. 15b. **Law enforcement authority.** "Law enforcement authority" means a
234.22 government agency or department within or outside Minnesota with jurisdiction to investigate
234.23 or bring a civil or criminal action against a child care provider, including a county, city, or
234.24 district attorney's office, the Attorney General's Office, a human services agency, a United
234.25 States attorney's office, or a law enforcement agency.

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

235.1 Sec. 6. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision
235.2 to read:

235.3 Subd. 19c. **Stop payment.** "Stop payment" means canceling a payment that was already
235.4 issued to a provider.

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

235.6 Sec. 7. Minnesota Statutes 2016, section 119B.02, subdivision 5, is amended to read:

235.7 Subd. 5. **Program integrity.** For child care assistance programs under this chapter, the
235.8 commissioner shall enforce the requirements for program integrity and fraud prevention
235.9 investigations under sections 256.046, 256.98, and 256.983 and chapter 245E.

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

235.11 Sec. 8. Minnesota Statutes 2016, section 119B.09, subdivision 9a, is amended to read:

235.12 Subd. 9a. **Child care centers; assistance.** ~~(a) For the purposes of this subdivision,~~
235.13 ~~"qualifying child" means a child who is not a child or dependent of an employee of the child~~
235.14 ~~care provider. A child care center may receive authorizations for 25 or fewer children who~~
235.15 ~~are dependents of the center's employees. If a child care center is authorized for more than~~
235.16 ~~25 children who are dependents of center employees, the county cannot authorize additional~~
235.17 ~~dependents of an employee until the number of children falls below 25.~~

235.18 ~~(b) Funds distributed under this chapter must not be paid for child care services that are~~
235.19 ~~provided for a child or dependent of an employee under paragraph (a) unless at all times at~~
235.20 ~~least 50 percent of the children for whom the child care provider is providing care are~~
235.21 ~~qualifying children under paragraph (a).~~

235.22 ~~(c) If a child care provider satisfies the requirements for payment under paragraph (b),~~
235.23 ~~but the percentage of qualifying children under paragraph (a) for whom the provider is~~
235.24 ~~providing care falls below 50 percent, the provider shall have four weeks to raise the~~
235.25 ~~percentage of qualifying children for whom the provider is providing care to at least 50~~
235.26 ~~percent before payments to the provider are discontinued for child care services provided~~
235.27 ~~for a child who is not a qualifying child.~~

235.28 ~~(d) This subdivision shall be implemented as follows:~~

235.29 ~~(1) no later than August 1, 2014, the commissioner shall issue a notice to providers who~~
235.30 ~~have been identified as ineligible for funds distributed under this chapter as described in~~
235.31 ~~paragraph (b); and~~

236.1 ~~(2) no later than January 5, 2015, payments to providers who do not comply with~~
 236.2 ~~paragraph (e) will be discontinued for child care services provided for children who are not~~
 236.3 ~~qualifying children.~~

236.4 ~~(e) If a child's authorization for child care assistance is terminated under this subdivision,~~
 236.5 ~~the county shall send a notice of adverse action to the provider and to the child's parent or~~
 236.6 ~~guardian, including information on the right to appeal, under Minnesota Rules, part~~
 236.7 ~~3400.0185.~~

236.8 ~~(f) (b) Funds paid to providers during the period of time between the issuance of a notice~~
 236.9 ~~under paragraph (d), clause (1), and discontinuation of payments under paragraph (d), clause~~
 236.10 ~~(2), when a center is authorized for more than 25 children who are dependents of center~~
 236.11 ~~employees must not be treated as overpayments under section 119B.11, subdivision 2a, due~~
 236.12 ~~to noncompliance with this subdivision.~~

236.13 ~~(g) (c) Nothing in this subdivision precludes the commissioner from conducting fraud~~
 236.14 ~~investigations relating to child care assistance, imposing sanctions, and obtaining monetary~~
 236.15 ~~recovery as otherwise provided by law.~~

236.16 **EFFECTIVE DATE.** This section is effective April 23, 2018.

236.17 **Sec. 9. [119B.097] AUTHORIZATION WITH A SECONDARY PROVIDER.**

236.18 (a) If a child uses any combination of the following providers paid by child care
 236.19 assistance, a parent must choose one primary provider and one secondary provider per child
 236.20 that can be paid by child care assistance:

236.21 (1) an individual or child care center licensed under chapter 245A;

236.22 (2) an individual or child care center or facility holding a valid child care license issued
 236.23 by another state or tribe; or

236.24 (3) a child care center exempt from licensing under section 245A.03.

236.25 (b) The amount of child care authorized with the secondary provider cannot exceed 20
 236.26 hours per two-week service period, per child, and the amount of care paid to a child's
 236.27 secondary provider is limited under section 119B.13, subdivision 1. The total amount of
 236.28 child care authorized with both the primary and secondary provider cannot exceed the
 236.29 amount of child care allowed based on the parents' eligible activity schedule, the child's
 236.30 school schedule, and any other factors relevant to the family's child care needs.

236.31 **EFFECTIVE DATE.** This section is effective April 23, 2018.

237.1 Sec. 10. Minnesota Statutes 2016, section 119B.125, subdivision 4, is amended to read:

237.2 Subd. 4. **Unsafe care.** A county may deny authorization as a child care provider to any
 237.3 applicant or ~~revoke~~ revoke the authorization of any provider when the county knows or has
 237.4 reason to believe that the provider is unsafe or that the circumstances of the chosen child
 237.5 care arrangement are unsafe. The county must include the conditions under which a provider
 237.6 or care arrangement will be determined to be unsafe in the county's child care fund plan
 237.7 under section 119B.08, subdivision 3.

237.8 **EFFECTIVE DATE.** This section is effective April 23, 2018.

237.9 Sec. 11. Minnesota Statutes 2016, section 119B.125, subdivision 6, is amended to read:

237.10 Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers
 237.11 receiving child care assistance payments must keep accurate and legible daily attendance
 237.12 records at the site where services are delivered for children receiving child care assistance
 237.13 and must make those records available immediately to the county or the commissioner upon
 237.14 request. The attendance records must be completed daily and include the date, the first and
 237.15 last name of each child in attendance, and the times when each child is dropped off and
 237.16 picked up. To the extent possible, the times that the child was dropped off to and picked up
 237.17 from the child care provider must be entered by the person dropping off or picking up the
 237.18 child. The daily attendance records must be retained at the site where services are delivered
 237.19 for six years after the date of service.

237.20 (b) A county or the commissioner may deny or revoke a provider's authorization as a
 237.21 ~~child care provider to any applicant, rescind authorization of any provider, to receive child~~
 237.22 care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a
 237.23 fraud disqualification under section 256.98, take an action against the provider under chapter
 237.24 245E, or establish an attendance record overpayment claim in the system under paragraph
 237.25 (c) against a current or former provider, when the county or the commissioner knows or
 237.26 has reason to believe that the provider has not complied with the record-keeping requirement
 237.27 in this subdivision. A provider's failure to produce attendance records as requested on more
 237.28 ~~than one occasion constitutes grounds for disqualification as a provider.~~

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

238.1 (d) The commissioner shall develop criteria to direct a county when the county must
 238.2 establish an attendance overpayment under this subdivision.

238.3 **EFFECTIVE DATE.** This section is effective April 23, 2018.

238.4 Sec. 12. Minnesota Statutes 2016, section 119B.13, subdivision 1, is amended to read:

238.5 Subdivision 1. **Subsidy restrictions.** (a) Beginning February 3, 2014, the maximum
 238.6 rate paid for child care assistance in any county or county price cluster under the child care
 238.7 fund shall be the greater of the 25th percentile of the 2011 child care provider rate survey
 238.8 or the maximum rate effective November 28, 2011. The commissioner may: (1) assign a
 238.9 county with no reported provider prices to a similar price cluster; and (2) consider county
 238.10 level access when determining final price clusters.

238.11 (b) A rate which includes a special needs rate paid under subdivision 3 may be in excess
 238.12 of the maximum rate allowed under this subdivision.

238.13 (c) The department shall monitor the effect of this paragraph on provider rates. The
 238.14 county shall pay the provider's full charges for every child in care up to the maximum
 238.15 established. The commissioner shall determine the maximum rate for each type of care on
 238.16 an hourly, full-day, and weekly basis, including special needs and disability care.

238.17 (d) If a child uses one provider, the maximum payment to a provider for one day of care
 238.18 must not exceed the daily rate. The maximum payment to a provider for one week of care
 238.19 must not exceed the weekly rate.

238.20 ~~(d)~~ (e) If a child uses two providers under section 119B.097, the maximum payment
 238.21 must not exceed:

238.22 (1) the daily rate for one day of care;

238.23 (2) the weekly rate for one week of care by a child's primary provider; and

238.24 (3) two daily rates during two weeks of care by a child's secondary provider.

238.25 (f) Child care providers receiving reimbursement under this chapter must not be paid
 238.26 activity fees or an additional amount above the maximum rates for care provided during
 238.27 nonstandard hours for families receiving assistance.

238.28 ~~(e)~~ (g) If the provider charge is greater than the maximum provider rate allowed,
 238.29 the parent is responsible for payment of the difference in the rates in addition to any family
 238.30 co-payment fee.

239.1 ~~(f)~~ (h) All maximum provider rates changes shall be implemented on the Monday
239.2 following the effective date of the maximum provider rate.

239.3 ~~(g)~~ (i) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum
239.4 registration fees in effect on January 1, 2013, shall remain in effect.

239.5 **EFFECTIVE DATE.** Paragraphs (d) to (i) are effective April 23, 2018.

239.6 Sec. 13. Minnesota Statutes 2016, section 119B.13, subdivision 6, is amended to read:

239.7 Subd. 6. **Provider payments.** (a) A provider must bill only for services documented
239.8 according to section 119B.125, subdivision 6. The provider shall bill for services provided
239.9 within ten days of the end of the service period. ~~If bills are submitted within ten days of the~~
239.10 ~~end of the service period,~~ Payments under the child care fund shall be made within ~~30~~ 21
239.11 days of receiving a complete bill from the provider. Counties or the state may establish
239.12 policies that make payments on a more frequent basis.

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

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

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

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

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

- 240.1 (3) the provider is in violation of child care assistance program rules, until the agency
 240.2 determines those violations have been corrected;
- 240.3 (4) the provider is operating after:
- 240.4 (i) an order of suspension of the provider's license issued by the commissioner; or
 240.5 (ii) an order of revocation of the provider's license; ~~or~~
 240.6 ~~(iii) a final order of conditional license issued by the commissioner for as long as the~~
 240.7 ~~conditional license is in effect;~~
- 240.8 (5) the provider submits ~~false~~ an inaccurate attendance reports ~~or refuses to provide~~
 240.9 ~~documentation of the child's attendance upon request; or~~ record;
- 240.10 (6) the provider gives false child care price information; or
- 240.11 (7) the provider fails to grant access to a county or the commissioner during regular
 240.12 business hours to examine all records necessary to determine the extent of services provided
 240.13 to a child care assistance recipient and the appropriateness of a claim for payment.
- 240.14 (e) If a county or the commissioner finds that a provider violated paragraph (d), clause
 240.15 (1) or (2), a county or the commissioner must deny or revoke the provider's authorization
 240.16 and either pursue a fraud disqualification under section 256.98, subdivision 8, paragraph
 240.17 (c), or refer the case to a law enforcement authority. A provider's rights related to an
 240.18 authorization denial or revocation under this paragraph are established in section 119B.161.
 240.19 If a provider's authorization is revoked or denied under this paragraph, the denial or
 240.20 revocation lasts until either:
- 240.21 (1) all criminal, civil, and administrative proceedings related to the provider's alleged
 240.22 misconduct conclude and any appeal rights are exhausted; or
- 240.23 (2) the commissioner decides, based on written evidence or argument submitted under
 240.24 section 119B.161, to authorize the provider.
- 240.25 (f) If a county or the commissioner denies or revokes a provider's authorization under
 240.26 paragraph (d), clause (4), the provider shall not be authorized until the order of suspension
 240.27 or order of revocation against the provider is lifted.
- 240.28 ~~(e) For purposes of~~ (g) If a county or the commissioner finds that a provider violated
 240.29 paragraph (d), clauses (3), (5), and or (6), the county or the commissioner may withhold
 240.30 revoke or deny the provider's authorization or payment for a period of time not to exceed
 240.31 three months beyond the time the condition has been corrected. If a provider's authorization

241.1 is revoked or denied under this paragraph, the denial or revocation may last up to 90 days
241.2 from the date a county or the commissioner denies or revokes the provider's authorization.

241.3 (h) If a county or the commissioner determines a provider violated paragraph (d), clause
241.4 (7), a county or the commissioner must deny or revoke the provider's authorization until a
241.5 county or the commissioner determines whether the records sought comply with this chapter
241.6 and chapter 245E. The provider's rights related to an authorization denial or revocation
241.7 under this paragraph are established in section 119B.161.

241.8 ~~(i)~~ (i) A county's payment policies must be included in the county's child care plan under
241.9 section 119B.08, subdivision 3. If payments are made by the state, in addition to being in
241.10 compliance with this subdivision, the payments must be made in compliance with section
241.11 16A.124.

241.12 **EFFECTIVE DATE.** Paragraph (a) is effective September 25, 2017. Paragraphs (d) to
241.13 (i) are effective April 23, 2018.

241.14 Sec. 14. Minnesota Statutes 2016, section 119B.16, subdivision 1, is amended to read:

241.15 Subdivision 1. **Fair hearing allowed for applicants and recipients.** (a) An applicant
241.16 or recipient adversely affected by an action of a county agency ~~action~~ or the commissioner
241.17 may request and receive a fair hearing in accordance with this subdivision and section
241.18 256.045.

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

241.23 (c) An applicant or recipient does not have a right to a fair hearing if a county agency
241.24 or the commissioner takes action against a provider.

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

241.28 **EFFECTIVE DATE.** This section is effective April 23, 2018.

241.29 Sec. 15. Minnesota Statutes 2016, section 119B.16, subdivision 1a, is amended to read:

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

242.1 ~~(b) A provider to whom a county agency has assigned responsibility for an overpayment~~
 242.2 ~~may request a fair hearing in accordance with section 256.045 for the limited purpose of~~
 242.3 ~~challenging the assignment of responsibility for the overpayment and the amount of the~~
 242.4 ~~overpayment. The scope of the fair hearing does not include the issues of whether the~~
 242.5 ~~provider wrongfully obtained public assistance in violation of section 256.98 or was properly~~
 242.6 ~~disqualified under section 256.98, subdivision 8, paragraph (c), unless the fair hearing has~~
 242.7 ~~been combined with an administrative disqualification hearing brought against the provider~~
 242.8 ~~under section 256.046.~~

242.9 (b) A provider may request a fair hearing only as specified in this subdivision.

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

242.12 (1) denies or revokes a provider's authorization, unless the action entitles the provider
 242.13 to a consolidated contested case hearing under section 119B.16, subdivision 3, or an
 242.14 administrative review under section 119B.161;

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

242.17 (3) establishes an overpayment for failure to comply with section 119B.125, subdivision
 242.18 6;

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

242.21 (5) initiates an administrative fraud disqualification hearing; or

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

242.23 (d) A provider may request a fair hearing by submitting a written request to the
 242.24 Department of Human Services, Appeals Division. A provider's request must be received
 242.25 by the appeals division no later than 30 days after the date a county or the commissioner
 242.26 mails the notice. The provider's appeal request must contain the following:

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

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

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

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

243.1 **EFFECTIVE DATE.** This section is effective April 23, 2018.

243.2 Sec. 16. Minnesota Statutes 2016, section 119B.16, subdivision 1b, is amended to read:

243.3 Subd. 1b. **Joint fair hearings.** ~~When a provider requests a fair hearing under subdivision~~
243.4 ~~1a, the family in whose case the overpayment was created must be made a party to the fair~~
243.5 ~~hearing. All other issues raised by the family must be resolved in the same proceeding.~~
243.6 ~~When a family requests a fair hearing and claims that the county should have assigned~~
243.7 ~~responsibility for an overpayment to a provider, the provider must be made a party to the~~
243.8 ~~fair hearing.~~ The human services judge assigned to a fair hearing may join a family or a
243.9 provider as a party to the fair hearing whenever joinder of that party is necessary to fully
243.10 and fairly resolve ~~overpayment~~ issues raised in the appeal.

243.11 **EFFECTIVE DATE.** This section is effective April 23, 2018.

243.12 Sec. 17. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision
243.13 to read:

243.14 **Subd. 1c. Notice to providers.** (a) Before taking an action appealable under subdivision
243.15 1a, paragraph (c), a county agency or the commissioner must mail written notice to the
243.16 provider against whom the action is being taken.

243.17 (b) The notice shall state:

243.18 (1) the factual basis for the department's determination;

243.19 (2) the action the department intends to take;

243.20 (3) the dollar amount of the monetary recovery or recoupment, if known; and

243.21 (4) the right to appeal the department's proposed action.

243.22 (c) A county agency or the commissioner must mail the written notice at least 15 calendar
243.23 days before the adverse action's effective date.

243.24 **EFFECTIVE DATE.** This section is effective April 23, 2018.

243.25 Sec. 18. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision
243.26 to read:

243.27 **Subd. 3. Consolidated contested case hearing.** If a county agency or the commissioner
243.28 denies or revokes a provider's authorization based on a licensing action, the provider may
243.29 only appeal the denial or revocation in the same contested case proceeding that the provider
243.30 appeals the licensing action.

244.1 **EFFECTIVE DATE.** This section is effective April 23, 2018.

244.2 Sec. 19. Minnesota Statutes 2016, section 119B.16, is amended by adding a subdivision
244.3 to read:

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

244.7 **EFFECTIVE DATE.** This section is effective April 23, 2018.

244.8 Sec. 20. **[119B.161] ADMINISTRATIVE REVIEW.**

244.9 Subdivision 1. **Temporary denial or revocation of authorization.** (a) A provider has
244.10 the rights listed under this section if:

244.11 (1) the provider's authorization was denied or revoked under section 119B.13, subdivision
244.12 6, paragraph (d), clause (1), (2), or (7);

244.13 (2) the provider's authorization was temporarily suspended under paragraph (b); or

244.14 (3) a payment was suspended under chapter 245E.

244.15 (b) Unless the commissioner receives a timely and proper request for an appeal, a county's
244.16 or the commissioner's action is a final department action.

244.17 (c) The commissioner may temporarily suspend a provider's authorization without prior
244.18 notice and opportunity for hearing if the commissioner determines either that there is a
244.19 credible allegation of fraud for which an investigation is pending under the child care
244.20 assistance program, or that the suspension is necessary for public safety and the best interests
244.21 of the child care assistance program. An allegation is considered credible if the allegation
244.22 has indications of reliability. The commissioner may determine that an allegation is credible,
244.23 if the commissioner reviewed all allegations, facts, and evidence carefully and acts judiciously
244.24 on a case-by-case basis.

244.25 Subd. 2. **Notice.** (a) A county or the commissioner must mail a provider notice within
244.26 five days of suspending, revoking, or denying a provider's authorization under subdivision
244.27 1.

244.28 (b) The notice must:

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

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

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

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

245.8 (c) Notwithstanding Minnesota Rules, part 3400.0185, if a county or the commissioner
245.9 denies or revokes a provider's authorization under section 119B.13, subdivision 6, paragraph
245.10 (d), clause (1), (2), or (7); suspends a payment to a provider under chapter 245E; or
245.11 temporarily suspends a payment to a provider under section 119B.161, subdivision 1, a
245.12 county or the commissioner must send notice of termination to an affected family. The
245.13 termination sent to an affected family is effective on the date the notice is created.

245.14 Subd. 3. **Duration.** If a provider's authorization is denied or revoked under section
245.15 119B.13, subdivision 6, paragraph (d), clause (1), (2), or (7); authorization is temporarily
245.16 suspended under section 119B.161; or payment is suspended under chapter 245E, the
245.17 provider's denial, revocation, temporary suspension, or payment suspension remains in
245.18 effect until:

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

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

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

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

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

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

246.1 **EFFECTIVE DATE.** This section is effective April 23, 2018.

246.2 Sec. 21. Minnesota Statutes 2016, section 245A.50, subdivision 5, is amended to read:

246.3 Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a)

246.4 License holders must document that before staff persons, caregivers, and helpers assist in
246.5 the care of infants, they are instructed on the standards in section 245A.1435 and receive
246.6 training on reducing the risk of sudden unexpected infant death. In addition, license holders
246.7 must document that before staff persons, caregivers, and helpers assist in the care of infants
246.8 and children under school age, they receive training on reducing the risk of abusive head
246.9 trauma from shaking infants and young children. The training in this subdivision may be
246.10 provided as initial training under subdivision 1 or ongoing annual training under subdivision
246.11 7.

246.12 (b) Sudden unexpected infant death reduction training required under this subdivision
246.13 must, at a minimum, address the risk factors related to sudden unexpected infant death,
246.14 means of reducing the risk of sudden unexpected infant death in child care, and license
246.15 holder communication with parents regarding reducing the risk of sudden unexpected infant
246.16 death.

246.17 (c) Abusive head trauma training required under this subdivision must, at a minimum,
246.18 address the risk factors related to shaking infants and young children, means of reducing
246.19 the risk of abusive head trauma in child care, and license holder communication with parents
246.20 regarding reducing the risk of abusive head trauma.

246.21 (d) Training for family and group family child care providers must be developed by the
246.22 commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved
246.23 by the Minnesota Center for Professional Development. Sudden unexpected infant death
246.24 reduction training and abusive head trauma training may be provided in a single course of
246.25 no more than two hours in length.

246.26 (e) Sudden unexpected infant death reduction training and abusive head trauma training
246.27 required under this subdivision must be completed in person or as allowed under subdivision
246.28 10, clause (1) or (2), at least once every two years. On the years when the license holder is
246.29 not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the
246.30 license holder must receive sudden unexpected infant death reduction training and abusive
246.31 head trauma training through a video of no more than one hour in length. The video must
246.32 be developed or approved by the commissioner.

247.1 (f) An individual who is related to the license holder as defined in section 245A.02,
 247.2 subdivision 13, and who is involved only in the care of the license holder's own infant or
 247.3 child under school age and who is not designated to be a caregiver, helper, or substitute, as
 247.4 defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the
 247.5 sudden unexpected infant death and abusive head trauma training.

247.6 Sec. 22. Minnesota Statutes 2016, section 245E.01, is amended by adding a subdivision
 247.7 to read:

247.8 Subd. 6a. **Credible allegation of fraud.** "Credible allegation of fraud" has the meaning
 247.9 given in section 256B.064, subdivision 2, paragraph (b), clause (2).

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

247.11 Sec. 23. Minnesota Statutes 2016, section 245E.02, subdivision 1, is amended to read:

247.12 Subdivision 1. **Investigating provider or recipient financial misconduct.** The
 247.13 department shall investigate alleged or suspected financial misconduct by providers and
 247.14 errors related to payments issued by the child care assistance program under this chapter.
 247.15 Recipients, employees, agents and consultants, and staff may be investigated when the
 247.16 evidence shows that their conduct is related to the financial misconduct of a provider, license
 247.17 holder, or controlling individual. When the alleged or suspected financial misconduct relates
 247.18 to acting as a recruiter offering conditional employment on behalf of a provider that has
 247.19 received funds from the child care assistance program, the department may investigate the
 247.20 provider, center owner, director, manager, license holder, or other controlling individual or
 247.21 agent, who is alleged to have acted as a recruiter offering conditional employment.

247.22 **EFFECTIVE DATE.** This section is effective April 23, 2018.

247.23 Sec. 24. Minnesota Statutes 2016, section 245E.02, subdivision 3, is amended to read:

247.24 Subd. 3. **Determination of investigation.** After completing its investigation, the
 247.25 department shall ~~issue one of the following determinations~~ determine that:

247.26 (1) no violation of child care assistance requirements occurred;

247.27 (2) there is insufficient evidence to show that a violation of child care assistance
 247.28 requirements occurred;

247.29 (3) a preponderance of evidence shows a violation of child care assistance program law,
 247.30 rule, or policy; or

247.31 (4) there exists a credible allegation of fraud involving the child care assistance program.

248.1 **EFFECTIVE DATE.** This section is effective April 23, 2018.

248.2 Sec. 25. Minnesota Statutes 2016, section 245E.02, subdivision 4, is amended to read:

248.3 Subd. 4. ~~Actions~~ **Referrals or administrative sanctions actions.** (a) After completing
248.4 the determination under subdivision 3, the department may take one or more of the actions
248.5 or sanctions specified in this subdivision.

248.6 (b) The department may take any of the following actions:

248.7 (1) refer the investigation to law enforcement or a county attorney for possible criminal
248.8 prosecution;

248.9 (2) refer relevant information to the department's licensing division, the background
248.10 studies division, the child care assistance program, the Department of Education, the federal
248.11 child and adult care food program, or appropriate child or adult protection agency;

248.12 (3) enter into a settlement agreement with a provider, license holder, owner, agent,
248.13 controlling individual, or recipient; or

248.14 (4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction
248.15 for possible civil action under the Minnesota False Claims Act, chapter 15C.

248.16 (c) In addition to section 256.98, the department may impose sanctions by:

248.17 (1) pursuing administrative disqualification through hearings or waivers;

248.18 (2) establishing and seeking monetary recovery or recoupment;

248.19 (3) issuing an order of corrective action that states the practices that are violations of
248.20 child care assistance program policies, laws, or regulations, and that they must be corrected;

248.21 ~~or~~

248.22 (4) ~~suspending, denying, or terminating~~ payments to a provider; or

248.23 (5) taking an action under section 119B.13, subdivision 6, paragraph (d).

248.24 (d) ~~Upon a finding by~~ If the commissioner determines that any child care provider, center
248.25 owner, director, manager, license holder, or other controlling individual of a child care
248.26 center has employed, used, or acted as a recruiter offering conditional employment for a
248.27 child care center that has received child care assistance program funding, the commissioner
248.28 shall:

248.29 (1) immediately suspend all program payments to all child care centers in which the
248.30 person employing, using, or acting as a recruiter offering conditional employment is an
248.31 owner, director, manager, license holder, or other controlling individual. The commissioner

249.1 shall suspend program payments under this clause even if services have already been
249.2 provided; and

249.3 (2) immediately and permanently revoke the licenses of all child care centers of which
249.4 the person employing, using, or acting as a recruiter offering conditional employment is an
249.5 owner, director, manager, license holder, or other controlling individual.

249.6 **EFFECTIVE DATE.** This section is effective April 23, 2018.

249.7 Sec. 26. Minnesota Statutes 2016, section 245E.03, subdivision 2, is amended to read:

249.8 Subd. 2. **Failure to provide access.** ~~Failure to provide access may result in denial or~~
249.9 ~~termination of authorizations for or payments to a recipient, provider, license holder, or~~
249.10 ~~controlling individual in the child care assistance program.~~ If a provider fails to grant the
249.11 department immediate access to records, the department may immediately suspend payments
249.12 under section 119B.161, or the department may deny or revoke the provider's authorization.
249.13 A provider, license holder, controlling individual, employee, or staff member must grant
249.14 the department access during any hours that the program is open to examine the provider's
249.15 program or the records listed in section 245E.05. A provider shall make records immediately
249.16 available at the provider's place of business at the time the department requests access,
249.17 unless the provider and the department both agree otherwise.

249.18 **EFFECTIVE DATE.** This section is effective April 23, 2018.

249.19 Sec. 27. Minnesota Statutes 2016, section 245E.03, subdivision 4, is amended to read:

249.20 Subd. 4. **Continued or repeated failure to provide access.** If the provider continues
249.21 to fail to provide access at the expiration of the 15-day notice period, child care assistance
249.22 program payments to the provider must be ~~denied~~ suspended beginning the 16th day
249.23 following notice of the initial failure or refusal to provide access. ~~The department may~~
249.24 ~~rescind the denial based upon good cause if the provider submits in writing a good cause~~
249.25 ~~basis for having failed or refused to provide access. The writing must be postmarked no~~
249.26 ~~later than the 15th day following the provider's notice of initial failure to provide access.~~ A
249.27 provider's, license holder's, controlling individual's, employee's, staff member's, or recipient's
249.28 duty to provide access in this section continues after the provider's authorization is denied,
249.29 revoked, or suspended. Additionally, the provider, license holder, or controlling individual
249.30 must immediately provide complete, ongoing access to the department. Repeated failures
249.31 to provide access must, after the initial failure or for any subsequent failure, result in
249.32 termination from participation in the child care assistance program.

250.1 **EFFECTIVE DATE.** This section is effective April 23, 2018.

250.2 Sec. 28. Minnesota Statutes 2016, section 245E.04, is amended to read:

250.3 **245E.04 HONEST AND TRUTHFUL STATEMENTS.**

250.4 It shall be unlawful for a provider, license holder, controlling individual, or recipient to:

250.5 (1) falsify, conceal, or cover up by any ~~trick, scheme, or device~~ a ~~material fact~~ means;

250.6 (2) make any materially false, fictitious, or fraudulent statement or representation; or

250.7 (3) make or use any false writing or document knowing the same to contain any materially
250.8 false, fictitious, or fraudulent statement or entry related to any child care assistance program
250.9 services that the provider, license holder, or controlling individual supplies or in relation to
250.10 any child care assistance payments received by a provider, license holder, or controlling
250.11 individual or to any fraud investigator or law enforcement officer conducting a financial
250.12 misconduct investigation.

250.13 **EFFECTIVE DATE.** This section is effective April 23, 2018.

250.14 Sec. 29. Minnesota Statutes 2016, section 245E.05, subdivision 1, is amended to read:

250.15 Subdivision 1. **Records required to be retained.** The following records must be
250.16 maintained, controlled, and made immediately accessible to license holders, providers, and
250.17 controlling individuals. The records must be organized and labeled to correspond to categories
250.18 that make them easy to identify so that they can be made available immediately upon request
250.19 to an investigator acting on behalf of the commissioner at the provider's place of business:

250.20 (1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting records;

250.21 (2) daily attendance records required by and that comply with section 119B.125,
250.22 subdivision 6;

250.23 (3) billing transmittal forms requesting payments from the child care assistance program
250.24 and billing adjustments related to child care assistance program payments;

250.25 (4) records identifying all persons, corporations, partnerships, and entities with an
250.26 ownership or controlling interest in the provider's child care business;

250.27 (5) employee or contractor records identifying those persons currently employed by the
250.28 provider's child care business or who have been employed by the business at any time within
250.29 the previous five years. The records must include each employee's name, hourly and annual
250.30 salary, qualifications, position description, job title, and dates of employment. In addition,

251.1 employee records that must be made available include the employee's time sheets, current
 251.2 home address of the employee or last known address of any former employee, and
 251.3 documentation of background studies required under chapter 119B or 245C;

251.4 (6) records related to transportation of children in care, including but not limited to:

251.5 (i) the dates and times that transportation is provided to children for transportation to
 251.6 and from the provider's business location for any purpose. For transportation related to field
 251.7 trips or locations away from the provider's business location, the names and addresses of
 251.8 those field trips and locations must also be provided;

251.9 (ii) the name, business address, phone number, and Web site address, if any, of the
 251.10 transportation service utilized; and

251.11 (iii) all billing or transportation records related to the transportation.

251.12 **EFFECTIVE DATE.** This section is effective April 23, 2018.

251.13 Sec. 30. Minnesota Statutes 2016, section 245E.06, subdivision 1, is amended to read:

251.14 Subdivision 1. **Factors regarding imposition of administrative ~~sanctions~~ actions.** (a)

251.15 The department shall consider the following factors in determining the administrative
 251.16 ~~sanctions~~ actions to be imposed:

251.17 (1) nature and extent of financial misconduct;

251.18 (2) history of financial misconduct;

251.19 (3) actions taken or recommended by other state agencies, other divisions of the
 251.20 department, and court and administrative decisions;

251.21 (4) prior ~~imposition of sanctions~~ actions;

251.22 (5) size and type of provider;

251.23 (6) information obtained through an investigation from any source;

251.24 (7) convictions or pending criminal charges; and

251.25 (8) any other information relevant to the acts or omissions related to the financial
 251.26 misconduct.

251.27 (b) Any single factor under paragraph (a) may be determinative of the department's
 251.28 decision of whether and what ~~sanctions are imposed~~ actions to take.

251.29 **EFFECTIVE DATE.** This section is effective April 23, 2018.

252.1 Sec. 31. Minnesota Statutes 2016, section 245E.06, subdivision 2, is amended to read:

252.2 Subd. 2. **Written notice of department ~~sanction action~~; sanction action effective**

252.3 **date; informal meeting.** (a) The department shall give notice in writing to a person of an
252.4 administrative sanction that is to be imposed. The notice shall be sent by mail as defined in
252.5 section ~~245E.01, subdivision 11.~~

252.6 ~~(b) The notice shall state:~~

252.7 ~~(1) the factual basis for the department's determination;~~

252.8 ~~(2) the sanction the department intends to take;~~

252.9 ~~(3) the dollar amount of the monetary recovery or recoupment, if any;~~

252.10 ~~(4) how the dollar amount was computed;~~

252.11 ~~(5) the right to dispute the department's determination and to provide evidence;~~

252.12 ~~(6) the right to appeal the department's proposed sanction; and~~

252.13 ~~(7) the option to meet informally with department staff, and to bring additional~~

252.14 ~~documentation or information, to resolve the issues.~~

252.15 ~~(e) In cases of determinations resulting in denial or termination of payments, in addition~~
252.16 ~~to the requirements of paragraph (b), the notice must state:~~

252.17 ~~(1) the length of the denial or termination;~~

252.18 ~~(2) the requirements and procedures for reinstatement; and~~

252.19 ~~(3) the provider's right to submit documents and written arguments against the denial~~

252.20 ~~or termination of payments for review by the department before the effective date of denial~~

252.21 ~~or termination.~~

252.22 ~~(d) The submission of documents and written argument for review by the department~~

252.23 ~~under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the deadline~~

252.24 ~~for filing an appeal.~~

252.25 (a) When taking an action against a provider, the department must give notice to:

252.26 (1) the provider as specified in section 119B.16 or 119B.161; and

252.27 (2) a family as specified under Minnesota Rules, part 3400.0185, or section 119B.161.

252.28 ~~(e)~~ (b) Notwithstanding section 245E.03, subdivision 4, and except for a payment

252.29 suspension or action under section 119B.161, subdivision 1, the effective date of the proposed

252.30 sanction action under this chapter shall be 30 days after the license holder's, provider's,

253.1 controlling individual's, or recipient's receipt of the notice, unless timely appealed. If a
 253.2 timely appeal is made, the proposed ~~sanction~~ action shall be delayed pending the final
 253.3 outcome of the appeal. Implementation of a proposed ~~sanction~~ action following the resolution
 253.4 of a timely appeal may be postponed if, in the opinion of the department, the delay of
 253.5 ~~sanction~~ action is necessary to protect the health or safety of children in care. ~~The department~~
 253.6 ~~may consider the economic hardship of a person in implementing the proposed sanction,~~
 253.7 ~~but economic hardship shall not be a determinative factor in implementing the proposed~~
 253.8 ~~sanction.~~

253.9 ~~(f) Requests for an informal meeting to attempt to resolve issues and requests for appeals~~
 253.10 ~~must be sent or delivered to the department's Office of Inspector General, Financial Fraud~~
 253.11 ~~and Abuse Division.~~

253.12 **EFFECTIVE DATE.** This section is effective April 23, 2018.

253.13 Sec. 32. Minnesota Statutes 2016, section 245E.06, subdivision 3, is amended to read:

253.14 Subd. 3. **Appeal of department sanction action.** ~~(a) If the department does not pursue~~
 253.15 ~~a criminal action against a provider, license holder, controlling individual, or recipient for~~
 253.16 ~~financial misconduct, but the department imposes an administrative sanction under section~~
 253.17 ~~245E.02, subdivision 4, paragraph (c), any individual or entity against whom the sanction~~
 253.18 ~~was imposed may appeal the department's administrative sanction under this section pursuant~~
 253.19 ~~to section 119B.16 or 256.045 with the additional requirements in clauses (1) to (4). An~~
 253.20 ~~appeal must specify:~~

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

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

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

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

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

253.30 ~~(c) Before the appeal hearing, the department may deny or terminate authorizations or~~
 253.31 ~~payment to the entity or individual if the department determines that the action is necessary~~
 253.32 ~~to protect the public welfare or the interests of the child care assistance program.~~

254.1 A provider's rights related to an action taken under this chapter are established in sections
254.2 119B.16 and 119B.161.

254.3 **EFFECTIVE DATE.** This section is effective April 23, 2018.

254.4 Sec. 33. Minnesota Statutes 2016, section 245E.07, subdivision 1, is amended to read:

254.5 Subdivision 1. **Grounds for and methods of monetary recovery.** (a) The department
254.6 may obtain monetary recovery from a provider who has been improperly paid by the child
254.7 care assistance program, regardless of whether the error was on the part of the provider, the
254.8 department, or the county and regardless of whether the error was intentional or county
254.9 error. The department does not need to establish a pattern as a ~~precondition of monetary~~
254.10 ~~recovery~~ of erroneous or false billing claims, duplicate billing claims, or billing claims
254.11 based on false statements or financial misconduct.

254.12 (b) The department shall obtain monetary recovery from providers by the following
254.13 means:

254.14 (1) permitting voluntary repayment of money, either in lump-sum payment or installment
254.15 payments;

254.16 (2) using any legal collection process;

254.17 (3) deducting or withholding program payments; or

254.18 (4) utilizing the means set forth in chapter 16D.

254.19 **EFFECTIVE DATE.** This section is effective April 23, 2018.

254.20 Sec. 34. Minnesota Statutes 2016, section 252.27, subdivision 2a, is amended to read:

254.21 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
254.22 including a child determined eligible for medical assistance without consideration of parental
254.23 income, must contribute to the cost of services used by making monthly payments on a
254.24 sliding scale based on income, unless the child is married or has been married, parental
254.25 rights have been terminated, or the child's adoption is subsidized according to chapter 259A
254.26 or through title IV-E of the Social Security Act. The parental contribution is a partial or full
254.27 payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating,
254.28 rehabilitation, maintenance, and personal care services as defined in United States Code,
254.29 title 26, section 213, needed by the child with a chronic illness or disability.

255.1 (b) For households with adjusted gross income equal to or greater than 275 percent of
255.2 federal poverty guidelines, the parental contribution shall be computed by applying the
255.3 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

255.4 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
255.5 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
255.6 contribution shall be determined using a sliding fee scale established by the commissioner
255.7 of human services which begins at ~~2.23~~ 1.94 percent of adjusted gross income at 275 percent
255.8 of federal poverty guidelines and increases to ~~6.08~~ 5.29 percent of adjusted gross income
255.9 for those with adjusted gross income up to 545 percent of federal poverty guidelines;

255.10 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
255.11 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
255.12 ~~6.08~~ 5.29 percent of adjusted gross income;

255.13 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
255.14 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
255.15 shall be determined using a sliding fee scale established by the commissioner of human
255.16 services which begins at ~~6.08~~ 5.29 percent of adjusted gross income at 675 percent of federal
255.17 poverty guidelines and increases to ~~8.1~~ 7.05 percent of adjusted gross income for those with
255.18 adjusted gross income up to 975 percent of federal poverty guidelines; and

255.19 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
255.20 guidelines, the parental contribution shall be ~~10.13~~ 8.81 percent of adjusted gross income.

255.21 If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400
255.22 prior to calculating the parental contribution. If the child resides in an institution specified
255.23 in section 256B.35, the parent is responsible for the personal needs allowance specified
255.24 under that section in addition to the parental contribution determined under this section.
255.25 The parental contribution is reduced by any amount required to be paid directly to the child
255.26 pursuant to a court order, but only if actually paid.

255.27 (c) The household size to be used in determining the amount of contribution under
255.28 paragraph (b) includes natural and adoptive parents and their dependents, including the
255.29 child receiving services. Adjustments in the contribution amount due to annual changes in
255.30 the federal poverty guidelines shall be implemented on the first day of July following
255.31 publication of the changes.

255.32 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
255.33 natural or adoptive parents determined according to the previous year's federal tax form,

256.1 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
256.2 have been used to purchase a home shall not be counted as income.

256.3 (e) The contribution shall be explained in writing to the parents at the time eligibility
256.4 for services is being determined. The contribution shall be made on a monthly basis effective
256.5 with the first month in which the child receives services. Annually upon redetermination
256.6 or at termination of eligibility, if the contribution exceeded the cost of services provided,
256.7 the local agency or the state shall reimburse that excess amount to the parents, either by
256.8 direct reimbursement if the parent is no longer required to pay a contribution, or by a
256.9 reduction in or waiver of parental fees until the excess amount is exhausted. All
256.10 reimbursements must include a notice that the amount reimbursed may be taxable income
256.11 if the parent paid for the parent's fees through an employer's health care flexible spending
256.12 account under the Internal Revenue Code, section 125, and that the parent is responsible
256.13 for paying the taxes owed on the amount reimbursed.

256.14 (f) The monthly contribution amount must be reviewed at least every 12 months; when
256.15 there is a change in household size; and when there is a loss of or gain in income from one
256.16 month to another in excess of ten percent. The local agency shall mail a written notice 30
256.17 days in advance of the effective date of a change in the contribution amount. A decrease in
256.18 the contribution amount is effective in the month that the parent verifies a reduction in
256.19 income or change in household size.

256.20 (g) Parents of a minor child who do not live with each other shall each pay the
256.21 contribution required under paragraph (a). An amount equal to the annual court-ordered
256.22 child support payment actually paid on behalf of the child receiving services shall be deducted
256.23 from the adjusted gross income of the parent making the payment prior to calculating the
256.24 parental contribution under paragraph (b).

256.25 (h) The contribution under paragraph (b) shall be increased by an additional five percent
256.26 if the local agency determines that insurance coverage is available but not obtained for the
256.27 child. For purposes of this section, "available" means the insurance is a benefit of employment
256.28 for a family member at an annual cost of no more than five percent of the family's annual
256.29 income. For purposes of this section, "insurance" means health and accident insurance
256.30 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
256.31 self-insured plan, or preferred provider organization.

256.32 Parents who have more than one child receiving services shall not be required to pay
256.33 more than the amount for the child with the highest expenditures. There shall be no resource
256.34 contribution from the parents. The parent shall not be required to pay a contribution in

257.1 excess of the cost of the services provided to the child, not counting payments made to
257.2 school districts for education-related services. Notice of an increase in fee payment must
257.3 be given at least 30 days before the increased fee is due.

257.4 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in
257.5 the 12 months prior to July 1:

257.6 (1) the parent applied for insurance for the child;

257.7 (2) the insurer denied insurance;

257.8 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
257.9 complaint or appeal, in writing, to the commissioner of health or the commissioner of
257.10 commerce, or litigated the complaint or appeal; and

257.11 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

257.12 For purposes of this section, "insurance" has the meaning given in paragraph (h).

257.13 A parent who has requested a reduction in the contribution amount under this paragraph
257.14 shall submit proof in the form and manner prescribed by the commissioner or county agency,
257.15 including, but not limited to, the insurer's denial of insurance, the written letter or complaint
257.16 of the parents, court documents, and the written response of the insurer approving insurance.
257.17 The determinations of the commissioner or county agency under this paragraph are not rules
257.18 subject to chapter 14.

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

257.20 Sec. 35. Minnesota Statutes 2016, section 256.98, subdivision 8, is amended to read:

257.21 Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of
257.22 wrongfully obtaining assistance by a federal or state court or by an administrative hearing
257.23 determination, or waiver thereof, through a disqualification consent agreement, or as part
257.24 of any approved diversion plan under section 401.065, or any court-ordered stay which
257.25 carries with it any probationary or other conditions, in the Minnesota family investment
257.26 program and any affiliated program to include the diversionary work program and the work
257.27 participation cash benefit program, the food stamp or food support program, the general
257.28 assistance program, the group residential housing program, or the Minnesota supplemental
257.29 aid program shall be disqualified from that program. In addition, any person disqualified
257.30 from the Minnesota family investment program shall also be disqualified from the food
257.31 stamp or food support program. The needs of that individual shall not be taken into
257.32 consideration in determining the grant level for that assistance unit:

- 258.1 (1) for one year after the first offense;
- 258.2 (2) for two years after the second offense; and
- 258.3 (3) permanently after the third or subsequent offense.

258.4 The period of program disqualification shall begin on the date stipulated on the advance
258.5 notice of disqualification without possibility of postponement for administrative stay or
258.6 administrative hearing and shall continue through completion unless and until the findings
258.7 upon which the sanctions were imposed are reversed by a court of competent jurisdiction.
258.8 The period for which sanctions are imposed is not subject to review. The sanctions provided
258.9 under this subdivision are in addition to, and not in substitution for, any other sanctions that
258.10 may be provided for by law for the offense involved. A disqualification established through
258.11 hearing or waiver shall result in the disqualification period beginning immediately unless
258.12 the person has become otherwise ineligible for assistance. If the person is ineligible for
258.13 assistance, the disqualification period begins when the person again meets the eligibility
258.14 criteria of the program from which they were disqualified and makes application for that
258.15 program.

258.16 (b) A family receiving assistance through child care assistance programs under chapter
258.17 119B with a family member who is found to be guilty of wrongfully obtaining child care
258.18 assistance by a federal court, state court, or an administrative hearing determination or
258.19 waiver, through a disqualification consent agreement, as part of an approved diversion plan
258.20 under section 401.065, or a court-ordered stay with probationary or other conditions, is
258.21 disqualified from child care assistance programs. The disqualifications must be for periods
258.22 of one year and two years for the first and second offenses, respectively. Subsequent
258.23 violations must result in permanent disqualification. During the disqualification period,
258.24 disqualification from any child care program must extend to all child care programs and
258.25 must be immediately applied.

258.26 (c) A provider caring for children receiving assistance through child care assistance
258.27 programs under chapter 119B is disqualified from receiving payment for child care services
258.28 from the child care assistance program under chapter 119B when the provider is found to
258.29 have wrongfully obtained child care assistance by a federal court, state court, or an
258.30 administrative hearing determination or waiver under section 256.046, through a
258.31 disqualification consent agreement, as part of an approved diversion plan under section
258.32 401.065, or a court-ordered stay with probationary or other conditions. The disqualification
258.33 must be for a period of ~~one year~~ two years for the first offense ~~and two years for the second~~
258.34 ~~offense~~. Any subsequent violation must result in permanent disqualification. The

259.1 disqualification period must be imposed immediately after a determination is made under
259.2 this paragraph. During the disqualification period, the provider is disqualified from receiving
259.3 payment from any child care program under chapter 119B.

259.4 (d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults
259.5 without children and upon federal approval, all categories of medical assistance and
259.6 remaining categories of MinnesotaCare, except for children through age 18, by a federal or
259.7 state court or by an administrative hearing determination, or waiver thereof, through a
259.8 disqualification consent agreement, or as part of any approved diversion plan under section
259.9 401.065, or any court-ordered stay which carries with it any probationary or other conditions,
259.10 is disqualified from that program. The period of disqualification is one year after the first
259.11 offense, two years after the second offense, and permanently after the third or subsequent
259.12 offense. The period of program disqualification shall begin on the date stipulated on the
259.13 advance notice of disqualification without possibility of postponement for administrative
259.14 stay or administrative hearing and shall continue through completion unless and until the
259.15 findings upon which the sanctions were imposed are reversed by a court of competent
259.16 jurisdiction. The period for which sanctions are imposed is not subject to review. The
259.17 sanctions provided under this subdivision are in addition to, and not in substitution for, any
259.18 other sanctions that may be provided for by law for the offense involved.

259.19 **EFFECTIVE DATE.** This section is effective April 23, 2018.

259.20 Sec. 36. Minnesota Statutes 2016, section 256E.30, subdivision 2, is amended to read:

259.21 Subd. 2. **Allocation of money.** (a) State money appropriated and community service
259.22 block grant money allotted to the state and all money transferred to the community service
259.23 block grant from other block grants shall be allocated annually to community action agencies
259.24 and Indian reservation governments under clauses (b) and (c), and to migrant and seasonal
259.25 farmworker organizations under clause (d).

259.26 (b) The available annual money will provide base funding to all community action
259.27 agencies and the Indian reservations. Base funding amounts per agency are as follows: for
259.28 agencies with low income populations up to ~~3,999~~ 1,999, \$25,000; ~~4,000~~ 2,000 to 23,999,
259.29 \$50,000; and 24,000 or more, \$100,000.

259.30 (c) All remaining money of the annual money available after the base funding has been
259.31 determined must be allocated to each agency and reservation in proportion to the size of
259.32 the poverty level population in the agency's service area compared to the size of the poverty
259.33 level population in the state.

260.1 (d) Allocation of money to migrant and seasonal farmworker organizations must not
 260.2 exceed three percent of the total annual money available. Base funding allocations must be
 260.3 made for all community action agencies and Indian reservations that received money under
 260.4 this subdivision, in fiscal year 1984, and for community action agencies designated under
 260.5 this section with a service area population of 35,000 or greater.

260.6 Sec. 37. Minnesota Statutes 2016, section 256J.24, subdivision 5, is amended to read:

260.7 Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based on the
 260.8 number of persons in the assistance unit eligible for both food and cash assistance. The
 260.9 amount of the transitional standard is published annually by the Department of Human
 260.10 Services. The following table represents the cash portion of the transitional standard effective
 260.11 March 1, 2018.

260.12	<u>Number of eligible people</u>	<u>Cash portion</u>
260.13	<u>1</u>	<u>\$263</u>
260.14	<u>2</u>	<u>\$450</u>
260.15	<u>3</u>	<u>\$545</u>
260.16	<u>4</u>	<u>\$634</u>
260.17	<u>5</u>	<u>\$710</u>
260.18	<u>6</u>	<u>\$786</u>
260.19	<u>7</u>	<u>\$863</u>
260.20	<u>8</u>	<u>\$929</u>
260.21	<u>9</u>	<u>\$993</u>
260.22	<u>10</u>	<u>\$1,048</u>
260.23	<u>Over 10</u>	<u>add \$56 for each additional eligible person</u>

260.24 Sec. 38. Minnesota Statutes 2016, section 256J.45, subdivision 2, is amended to read:

260.25 Subd. 2. **General information.** The MFIP orientation must consist of a presentation
 260.26 that informs caregivers of:

260.27 (1) the necessity to obtain immediate employment;

260.28 (2) the work incentives under MFIP, including the availability of the federal earned
 260.29 income tax credit and the Minnesota working family tax credit;

260.30 (3) the requirement to comply with the employment plan and other requirements of the
 260.31 employment and training services component of MFIP, including a description of the range
 260.32 of work and training activities that are allowable under MFIP to meet the individual needs
 260.33 of participants;

261.1 (4) the consequences for failing to comply with the employment plan and other program
 261.2 requirements, and that the county agency may not impose a sanction when failure to comply
 261.3 is due to the unavailability of child care or other circumstances where the participant has
 261.4 good cause under subdivision 3;

261.5 (5) the rights, responsibilities, and obligations of participants;

261.6 (6) the types and locations of child care services available through the county agency;

261.7 (7) the availability and the benefits of the early childhood health and developmental
 261.8 screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

261.9 (8) the caregiver's eligibility for transition year child care assistance under section
 261.10 119B.05;

261.11 (9) the availability of all health care programs, including transitional medical assistance;

261.12 (10) the caregiver's option to choose an employment and training provider and information
 261.13 about each provider, including but not limited to, services offered, program components,
 261.14 job placement rates, job placement wages, and job retention rates;

261.15 (11) the caregiver's option to request approval of an education and training plan according
 261.16 to section 256J.53;

261.17 (12) the work study programs available under the higher education system; ~~and~~

261.18 (13) information about the 60-month time limit exemptions under the family violence
 261.19 waiver and referral information about shelters and programs for victims of family violence;
 261.20 and

261.21 (14) information about the income exclusions in section 256P.06, subdivision 2b.

261.22 **EFFECTIVE DATE.** This section is effective July 1, 2018.

261.23 Sec. 39. **[256N.261] SUPPORT FOR ADOPTIVE, FOSTER, AND KINSHIP**
 261.24 **FAMILIES.**

261.25 Subdivision 1. **Program established.** The commissioner shall design and implement a
 261.26 coordinated program to reduce the need for placement changes or out-of-home placements
 261.27 of children and youth in foster care, adoptive placements, and permanent physical and legal
 261.28 custody kinship placements, and to improve the functioning and stability of these families.
 261.29 To the extent federal funds are available, the commissioner shall provide the following
 261.30 adoption and foster care-competent services and ensure that placements are trauma-informed
 261.31 and child and family-centered:

262.1 (1) a program providing information, referrals, a parent-to-parent support network, peer
 262.2 support for youth, family activities, respite care, crisis services, educational support, and
 262.3 mental health services for children and youth in adoption, foster care, and kinship placements
 262.4 and adoptive, foster, and kinship families in Minnesota;

262.5 (2) training offered statewide in Minnesota for adoptive and kinship families, and training
 262.6 for foster families, and the professionals who serve the families, on the effects of trauma,
 262.7 common disabilities of adopted children and children in foster care, and kinship placements,
 262.8 and challenges in adoption, foster care, and kinship placements; and

262.9 (3) periodic evaluation of these services to ensure program effectiveness in preserving
 262.10 and improving the success of adoptive, foster, and kinship placements.

262.11 Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

262.12 (b) "Child and family-centered" means individualized services that respond to a child's
 262.13 or youth's strengths, interests, and current developmental stage, including social, cognitive,
 262.14 emotional, physical, cultural, racial, and spiritual needs, and offer support to the entire
 262.15 adoptive, foster, or kinship family.

262.16 (c) "Trauma-informed" means care that acknowledges the effect trauma has on children
 262.17 and the children's families; modifies services to respond to the effects of trauma; emphasizes
 262.18 skill and strength-building rather than symptom management; and focuses on the physical
 262.19 and psychological safety of the child and family.

262.20 Sec. 40. Minnesota Statutes 2016, section 256P.06, subdivision 2, is amended to read:

262.21 Subd. 2. **Exempted individuals.** (a) The following members of an assistance unit under
 262.22 chapters 119B and 256J are exempt from having their earned income count towards the
 262.23 income of an assistance unit:

262.24 (1) children under six years old;

262.25 (2) caregivers under 20 years of age enrolled at least half-time in school; and

262.26 (3) minors enrolled in school full time.

262.27 (b) The following members of an assistance unit are exempt from having their earned
 262.28 and unearned income count towards the income of an assistance unit for 12 consecutive
 262.29 calendar months, beginning the month following the marriage date, for benefits under chapter
 262.30 256J if the household income does not exceed 275 percent of the federal poverty guideline:

262.31 (1) a new spouse to a caretaker in an existing assistance unit; and

263.1 (2) the spouse designated by a newly married couple, both of whom were already
 263.2 members of an assistance unit under chapter 256J.

263.3 (c) If members identified in paragraph (b) also receive assistance under section 119B.05,
 263.4 they are exempt from having their earned and unearned income count towards the income
 263.5 of the assistance unit if the household income prior to the exemption does not exceed 67
 263.6 percent of the state median income for recipients for 26 consecutive biweekly periods
 263.7 beginning the second biweekly period after the marriage date.

263.8 **EFFECTIVE DATE.** This section is effective July 1, 2018.

263.9 Sec. 41. Minnesota Statutes 2016, section 260C.451, subdivision 6, is amended to read:

263.10 Subd. 6. **Reentering foster care and accessing services after 18 years of age and up**
 263.11 **to 21 years of age.** (a) Upon request of an individual who had been under the guardianship
 263.12 of the commissioner and who has left foster care without being adopted, the responsible
 263.13 social services agency which had been the commissioner's agent for purposes of the
 263.14 guardianship shall develop with the individual a plan to increase the individual's ability to
 263.15 live safely and independently using the plan requirements of section 260C.212, subdivision
 263.16 1, paragraph (c), clause (12), and to assist the individual to meet one or more of the eligibility
 263.17 criteria in subdivision 4 if the individual wants to reenter foster care. The responsible social
 263.18 services agency shall provide foster care as required to implement the plan. The responsible
 263.19 social services agency shall enter into a voluntary placement agreement under section
 263.20 260C.229 with the individual if the plan includes foster care.

263.21 (b) Individuals who had not been under the guardianship of the commissioner of human
 263.22 services prior to 18 years of age may ask to reenter foster care after age 18 and, ~~to the extent~~
 263.23 ~~funds are available,~~ the responsible social services agency that had responsibility for planning
 263.24 for the individual before discharge from foster care ~~may~~ shall provide foster care or other
 263.25 services to the individual for the purpose of increasing the individual's ability to live safely
 263.26 and independently and to meet the eligibility criteria in subdivision 3a, if the individual:

263.27 (1) was in foster care for the six consecutive months prior to the person's 18th birthday,
 263.28 or left foster care within six months prior to the person's 18th birthday, and was not
 263.29 discharged home, adopted, or received into a relative's home under a transfer of permanent
 263.30 legal and physical custody under section 260C.515, subdivision 4; or

263.31 (2) was discharged from foster care while on runaway status after age 15.

263.32 (c) In conjunction with a qualifying and eligible individual under paragraph (b) and
 263.33 other appropriate persons, the responsible social services agency shall develop a specific

264.1 plan related to that individual's vocational, educational, social, or maturational needs and;
264.2 ~~to the extent funds are available~~, provide foster care as required to implement the plan. The
264.3 responsible social services agency shall enter into a voluntary placement agreement with
264.4 the individual if the plan includes foster care.

264.5 (d) A child who left foster care while under guardianship of the commissioner of human
264.6 services retains eligibility for foster care for placement at any time prior to 21 years of age.

264.7 Sec. 42. Minnesota Statutes 2016, section 626.556, subdivision 10j, is amended to read:

264.8 Subd. 10j. **Release of data to mandated reporters.** (a) A local social services or child
264.9 protection agency, or the agency responsible for assessing or investigating the report of
264.10 maltreatment or for providing child protective services, shall provide relevant private data
264.11 on individuals obtained under this section to a mandated reporter who made the report and
264.12 who has an ongoing responsibility for the health, education, or welfare of a child affected
264.13 by the data, unless the agency determines that providing the data would not be in the best
264.14 interests of the child. The agency may provide the data to other mandated reporters with
264.15 ongoing responsibility for the health, education, or welfare of the child. Mandated reporters
264.16 with ongoing responsibility for the health, education, or welfare of a child affected by the
264.17 data include the child's teachers or other appropriate school personnel, foster parents, health
264.18 care providers, respite care workers, therapists, social workers, child care providers,
264.19 residential care staff, crisis nursery staff, probation officers, and court services personnel.
264.20 Under this section, a mandated reporter need not have made the report to be considered a
264.21 person with ongoing responsibility for the health, education, or welfare of a child affected
264.22 by the data. Data provided under this section must be limited to data pertinent to the
264.23 individual's responsibility for caring for the child.

264.24 (b) A reporter who receives private data on individuals under this subdivision must treat
264.25 the data according to that classification, regardless of whether the reporter is an employee
264.26 of a government entity. The remedies and penalties under sections 13.08 and 13.09 apply
264.27 if a reporter releases data in violation of this section or other law.

264.28 Sec. 43. **MINNESOTA BIRTH TO EIGHT PILOT PROJECT.**

264.29 Subdivision 1. **Authorization.** The commissioner of human services shall award a grant
264.30 to Dakota County to develop and implement pilots that will evaluate the impact of a
264.31 coordinated systems and service delivery approach on key developmental milestones and
264.32 outcomes that ultimately lead to reading proficiency by age eight within the target population.
264.33 The pilot program is from July 1, 2017, to June 30, 2021.

265.1 Subd. 2. **Pilot design and goals.** The pilot will establish five key developmental milestone
265.2 markers from birth to age eight. Enrollees in the pilot will be developmentally assessed and
265.3 tracked by a technology solution that tracks developmental milestones along the established
265.4 developmental continuum. If a child's progress falls below established milestones and the
265.5 weighted scoring, the coordinated service system will focus on identified areas of concern,
265.6 mobilize appropriate supportive services, and offer services to identified children and their
265.7 families.

265.8 Subd. 3. **Program participants in phase 1 target population.** Pilot program participants
265.9 must:

265.10 (1) be enrolled in a Women's Infant & Children (WIC) program;

265.11 (2) be participating in a family home visiting program, or nurse family practice, or
265.12 Healthy Families America (HFA);

265.13 (3) be children and families qualifying for and participating in early language learners
265.14 (ELL) in the school district in which they reside; and

265.15 (4) be voluntarily willing to participate in the pilot.

265.16 Subd. 4. **Evaluation and report.** The county or counties shall work with a third-party
265.17 evaluator to evaluate the effectiveness of the pilot and report back to the legislature each
265.18 year by February 1 with an update on the progress of the pilot. The final report on the pilot
265.19 is due January 1, 2022.

265.20 Sec. 44. **MINNESOTA PATHWAYS TO PROSPERITY PILOT PROJECT.**

265.21 Subdivision 1. **Authorization.** The commissioner of human services may develop a
265.22 pilot that will test an alternative financing model for the distribution of publicly funded
265.23 benefits. The commissioner may work with interested counties to develop the pilot and
265.24 determine the waivers that are necessary to implement the pilot program based on the pilot
265.25 design in subdivisions 2 and 3, and outcome measures in subdivision 4.

265.26 Subd. 2. **Pilot program design and goals.** The pilot program must reduce the historical
265.27 separation between the state funds and systems affecting families who are receiving public
265.28 assistance. The pilot program shall eliminate, where possible, funding restrictions to allow
265.29 a more comprehensive approach to the needs of the families in the pilot program, and focus
265.30 on upstream, prevention-oriented supports and interventions.

265.31 Subd. 3. **Program participants.** Pilot program participants must:

265.32 (1) be 26 years of age or younger with a minimum of one child;

266.1 (2) voluntarily agree to participate in the pilot program;

266.2 (3) be eligible for, applying for, or receiving public benefits including but not limited
 266.3 to housing assistance, education supports, employment supports, child care, transportation
 266.4 supports, medical assistance, earned income tax credit, or the child care tax credit; and

266.5 (4) be enrolled in an education program that is focused on obtaining a career that will
 266.6 likely result in a livable wage.

266.7 Subd. 4. **Outcomes.** The outcomes measures for the pathways to prosperity include:

266.8 (1) improvement in the affordability, safety, and permanence of suitable housing;

266.9 (2) improvement in family functioning and stability, including in the areas of behavioral
 266.10 health, incarceration, involvement with the child welfare system, or equivalent indicators;

266.11 (3) secure educational gains for parent and specifically for children from early childhood
 266.12 through high school, including absentee reduction, preschool readiness scores, third grade
 266.13 reading competency, graduation, GPA, and standardized test improvement;

266.14 (4) improvement in attachment to the workforce of one or both adults, including enhanced
 266.15 job stability; wage gains; career advancement; progress in career preparation; or an equivalent
 266.16 combination of these or related measures; and

266.17 (5) improvement in health access and health outcomes for parents and children.

266.18 Sec. 45. **REPEALER.**

266.19 Minnesota Statutes 2016, sections 13.468; and 256J.626, subdivision 5, are repealed.

266.20 **ARTICLE 8**

266.21 **CHEMICAL AND MENTAL HEALTH SERVICES**

266.22 Section 1. **[245.4662] GRANT PROGRAM; MENTAL HEALTH INNOVATION.**

266.23 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
 266.24 the meaning given them:

266.25 (b) "Community partnership" means a project involving the collaboration of two or more
 266.26 eligible applicants.

266.27 (c) "Eligible applicant" means an eligible county, Indian tribe, mental health service
 266.28 provider, hospital, or community partnership. Eligible applicant does not include a
 266.29 state-operated direct care and treatment facility or program under chapter 246.

267.1 (d) "Intensive residential treatment services" has the meaning given in section 256B.0622,
267.2 subdivision 2.

267.3 (e) "Metropolitan area" means the seven-county metropolitan area, as defined in section
267.4 473.121, subdivision 2.

267.5 Subd. 2. **Grants authorized.** The commissioner of human services shall award grants
267.6 to eligible applicants to plan, establish, or operate programs to improve accessibility and
267.7 quality of community-based, outpatient mental health services and reduce the number of
267.8 clients admitted to regional treatment centers and community behavioral health hospitals.
267.9 The commissioner shall award half of all grant funds to eligible applicants in the metropolitan
267.10 area and half of all grant funds to eligible applicants outside the metropolitan area. The
267.11 commissioner shall publish criteria for grant awards no later than September 1, 2017.

267.12 Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an applicant
267.13 must submit an application to the commissioner of human services by October 31, 2017,
267.14 and by October 31 each year thereafter. A grant may be awarded upon the signing of a grant
267.15 contract. An applicant may apply for and the commissioner may award grants for one-year
267.16 or two-year periods.

267.17 (b) An application must be on a form and contain information as specified by the
267.18 commissioner but at a minimum must contain:

267.19 (1) a description of the purpose or project for which grant funds will be used;

267.20 (2) a description of the specific problem the grant funds will address;

267.21 (3) a description of achievable objectives, a work plan, and a timeline for implementation
267.22 and completion of processes or projects enabled by the grant; and

267.23 (4) a process for documenting and evaluating results of the grant.

267.24 (c) The commissioner shall review each application to determine whether the application
267.25 is complete and whether the applicant and the project are eligible for a grant. In evaluating
267.26 applications according to paragraph (d), the commissioner shall establish criteria including,
267.27 but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in
267.28 describing the problem grant funds are intended to address; a description of the applicant's
267.29 proposed project; a description of the population demographics and service area of the
267.30 proposed project; the manner in which the applicant will demonstrate the effectiveness of
267.31 any projects undertaken; and evidence of efficiencies and effectiveness gained through
267.32 collaborative efforts. The commissioner may also consider other relevant factors, including,
267.33 but not limited to, the proposed project's longevity and financial sustainability. In evaluating

268.1 applications, the commissioner may request additional information regarding a proposed
 268.2 project, including information on project cost. An applicant's failure to provide the
 268.3 information requested disqualifies an applicant. The commissioner shall determine the
 268.4 number of grants awarded.

268.5 (d) In determining whether eligible applicants receive grants under this section, the
 268.6 commissioner shall give preference to the following:

268.7 (1) intensive residential treatment services, providing time-limited mental health services
 268.8 in a residential setting;

268.9 (2) the creation of stand-alone urgent care centers for mental health and psychiatric
 268.10 consultation services, crisis residential services or collaboration between crisis teams and
 268.11 critical access hospitals;

268.12 (3) establishing new community mental health services or expanding the capacity of
 268.13 existing services; and

268.14 (4) other innovative projects that improve options for mental health services in community
 268.15 settings and reduce the number of clients who remain in regional treatment centers and
 268.16 community behavioral health hospitals beyond when discharge is determined to be clinically
 268.17 appropriate.

268.18 Subd. 4. **Awarding of grants.** The commissioner must notify grantees of awards by
 268.19 December 15, 2017, and grant funds must be disbursed by January 1, 2018, and by December
 268.20 15 and January 1, respectively, each year thereafter.

268.21 Sec. 2. Minnesota Statutes 2016, section 245.4889, subdivision 1, is amended to read:

268.22 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
 268.23 make grants from available appropriations to assist:

268.24 (1) counties;

268.25 (2) Indian tribes;

268.26 (3) children's collaboratives under section 124D.23 or 245.493; or

268.27 (4) mental health service providers.

268.28 (b) The following services are eligible for grants under this section:

268.29 (1) services to children with emotional disturbances as defined in section 245.4871,
 268.30 subdivision 15, and their families;

- 269.1 (2) transition services under section 245.4875, subdivision 8, for young adults under
269.2 age 21 and their families;
- 269.3 (3) respite care services for children with severe emotional disturbances who are at risk
269.4 of out-of-home placement;
- 269.5 (4) children's mental health crisis services;
- 269.6 (5) mental health services for people from cultural and ethnic minorities;
- 269.7 (6) children's mental health screening and follow-up diagnostic assessment and treatment;
- 269.8 (7) services to promote and develop the capacity of providers to use evidence-based
269.9 practices in providing children's mental health services;
- 269.10 (8) school-linked mental health services;
- 269.11 (9) building evidence-based mental health intervention capacity for children birth to age
269.12 five;
- 269.13 (10) suicide prevention and counseling services that use text messaging statewide;
- 269.14 (11) mental health first aid training;
- 269.15 (12) training for parents, collaborative partners, and mental health providers on the
269.16 impact of adverse childhood experiences and trauma and development of an interactive
269.17 Web site to share information and strategies to promote resilience and prevent trauma;
- 269.18 (13) transition age services to develop or expand mental health treatment and supports
269.19 for adolescents and young adults 26 years of age or younger;
- 269.20 (14) early childhood mental health consultation;
- 269.21 (15) evidence-based interventions for youth at risk of developing or experiencing a first
269.22 episode of psychosis, and a public awareness campaign on the signs and symptoms of
269.23 psychosis; ~~and~~
- 269.24 (16) psychiatric consultation for primary care practitioners;
- 269.25 (17) providers to begin operations and meet program requirements when establishing a
269.26 new children's mental health program. These may be start-up grants; and
- 269.27 (18) transportation for children to school-linked mental health services.
- 269.28 (c) Services under paragraph ~~(b)~~ must be designed to help each child to function and
269.29 remain with the child's family in the community and delivered consistent with the child's

270.1 treatment plan. Transition services to eligible young adults under this paragraph ~~(b)~~ must
270.2 be designed to foster independent living in the community.

270.3 **EFFECTIVE DATE.** Clause (17) is effective the day following final enactment.

270.4 Sec. 3. Minnesota Statutes 2016, section 245.91, subdivision 4, is amended to read:

270.5 Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or
270.6 residential program as defined in section 245A.02, subdivisions 10 and 14, ~~that is required~~
270.7 ~~to be licensed by the commissioner of human services, and any agency, facility, or program~~
270.8 that provides services or treatment for mental illness, developmental disabilities, chemical
270.9 dependency, or emotional disturbance that is required to be licensed, certified, or registered
270.10 by the commissioner of human services, health, or education; and an acute care inpatient
270.11 facility that provides services or treatment for mental illness, developmental disabilities,
270.12 chemical dependency, or emotional disturbance.

270.13 Sec. 4. Minnesota Statutes 2016, section 245.91, subdivision 6, is amended to read:

270.14 Subd. 6. **Serious injury.** "Serious injury" means:

270.15 (1) fractures;

270.16 (2) dislocations;

270.17 (3) evidence of internal injuries;

270.18 (4) head injuries with loss of consciousness or potential for a closed head injury or
270.19 concussion without loss of consciousness requiring a medical assessment by a health care
270.20 professional, whether or not further medical attention was sought;

270.21 (5) lacerations involving injuries to tendons or organs, and those for which complications
270.22 are present;

270.23 (6) extensive second-degree or third-degree burns, and other burns for which
270.24 complications are present;

270.25 (7) extensive second-degree or third-degree frostbite, and others for which complications
270.26 are present;

270.27 (8) irreversible mobility or avulsion of teeth;

270.28 (9) injuries to the eyeball;

270.29 (10) ingestion of foreign substances and objects that are harmful;

270.30 (11) near drowning;

271.1 (12) heat exhaustion or sunstroke; ~~and~~

271.2 (13) attempted suicide; and

271.3 ~~(13)~~ (14) all other injuries and incidents considered serious after an assessment by a
 271.4 ~~physician.~~ health care professional, including but not limited to self-injurious behavior, a
 271.5 medication error requiring medical treatment, a suspected delay of medical treatment, a
 271.6 complication of a previous injury, or a complication of medical treatment for an injury.

271.7 Sec. 5. Minnesota Statutes 2016, section 245.94, subdivision 1, is amended to read:

271.8 Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which
 271.9 complaints to the office are to be made, reviewed, and acted upon. The ombudsman may
 271.10 not levy a complaint fee.

271.11 (b) The ombudsman is a health oversight agency as defined in Code of Federal
 271.12 Regulations, title 45, section 164.501. The ombudsman may access patient records according
 271.13 to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph,
 271.14 "records" has the meaning given in Code of Federal Regulations, title 42, section
 271.15 2.53(a)(1)(i).

271.16 ~~(b)~~ (c) The ombudsman may mediate or advocate on behalf of a client.

271.17 ~~(c)~~ (d) The ombudsman may investigate the quality of services provided to clients and
 271.18 determine the extent to which quality assurance mechanisms within state and county
 271.19 government work to promote the health, safety, and welfare of clients, ~~other than clients in~~
 271.20 ~~acute care facilities who are receiving services not paid for by public funds. The ombudsman~~
 271.21 ~~is a health oversight agency as defined in Code of Federal Regulations, title 45, section~~
 271.22 ~~164.501.~~

271.23 ~~(d)~~ (e) At the request of a client, or upon receiving a complaint or other information
 271.24 affording reasonable grounds to believe that the rights of ~~a client~~ one or more clients who
 271.25 ~~is~~ may not be capable of requesting assistance have been adversely affected, the ombudsman
 271.26 may gather information and data about and analyze, on behalf of the client, the actions of
 271.27 an agency, facility, or program.

271.28 ~~(e)~~ (f) the ombudsman may gather, on behalf of ~~a client~~ one or more clients, records of
 271.29 an agency, facility, or program, or records related to clinical drug trials from the University
 271.30 of Minnesota Department of Psychiatry, if the records relate to a matter that is within the
 271.31 scope of the ombudsman's authority. If the records are private and the client is capable of
 271.32 providing consent, the ombudsman shall first obtain the client's consent. The ombudsman
 271.33 is not required to obtain consent for access to private data on clients with developmental

272.1 disabilities and individuals served by the Minnesota sex offender program. The ombudsman
272.2 may also take photographic or videographic evidence while reviewing the actions of an
272.3 agency, facility, or program, with the consent of the client. The ombudsman is not required
272.4 to obtain consent for access to private data on decedents who were receiving services for
272.5 mental illness, developmental disabilities, chemical dependency, or emotional disturbance.
272.6 All data collected, created, received, or maintained by the ombudsman are governed by
272.7 chapter 13 and other applicable law.

272.8 ~~(f)~~ (g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person
272.9 to appear, give testimony, or produce documents or other evidence that the ombudsman
272.10 considers relevant to a matter under inquiry. The ombudsman may petition the appropriate
272.11 court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part
272.12 of an investigation possesses the same privileges that a witness possesses in the courts or
272.13 under the law of this state. Data obtained from a person under this paragraph are private
272.14 data as defined in section 13.02, subdivision 12.

272.15 ~~(g)~~ (h) The ombudsman may, at reasonable times in the course of conducting a review,
272.16 enter and view premises within the control of an agency, facility, or program.

272.17 ~~(h)~~ (i) The ombudsman may attend Department of Human Services Review Board and
272.18 Special Review Board proceedings; proceedings regarding the transfer of clients, as defined
272.19 in section 246.50, subdivision 4, between institutions operated by the Department of Human
272.20 Services; and, subject to the consent of the affected client, other proceedings affecting the
272.21 rights of clients. The ombudsman is not required to obtain consent to attend meetings or
272.22 proceedings and have access to private data on clients with developmental disabilities and
272.23 individuals served by the Minnesota sex offender program.

272.24 ~~(i)~~ (j) The ombudsman shall gather data of agencies, facilities, or programs classified
272.25 as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding
272.26 services provided to clients with developmental disabilities and individuals served by the
272.27 Minnesota sex offender program.

272.28 ~~(j)~~ (k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant
272.29 licensing or regulatory officials before undertaking a review of an action of the facility or
272.30 program.

272.31 (l) The Office of Ombudsman shall provide the services of the Civil Commitment
272.32 Training and Resource Center.

272.33 ~~(k)~~ (m) The ombudsman shall monitor the treatment of individuals participating in a
272.34 University of Minnesota Department of Psychiatry clinical drug trial and ensure that all

273.1 protections for human subjects required by federal law and the Institutional Review Board
273.2 are provided.

273.3 ~~(H)~~ (n) Sections 245.91 to 245.97 are in addition to other provisions of law under which
273.4 any other remedy or right is provided.

273.5 Sec. 6. Minnesota Statutes 2016, section 245.97, subdivision 6, is amended to read:

273.6 Subd. 6. **Terms, compensation, and removal.** The membership terms, compensation,
273.7 and removal of members of the committee and the filling of membership vacancies are
273.8 governed by section ~~15.0575~~ 15.0597.

273.9 Sec. 7. Minnesota Statutes 2016, section 245A.03, subdivision 2, is amended to read:

273.10 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

273.11 (1) residential or nonresidential programs that are provided to a person by an individual
273.12 who is related unless the residential program is a child foster care placement made by a
273.13 local social services agency or a licensed child-placing agency, except as provided in
273.14 subdivision 2a;

273.15 (2) nonresidential programs that are provided by an unrelated individual to persons from
273.16 a single related family;

273.17 (3) residential or nonresidential programs that are provided to adults who do not ~~abuse~~
273.18 ~~chemicals or who do not have a chemical dependency~~ misuse substances or have a substance
273.19 use disorder, a mental illness, a developmental disability, a functional impairment, or a
273.20 physical disability;

273.21 (4) sheltered workshops or work activity programs that are certified by the commissioner
273.22 of employment and economic development;

273.23 (5) programs operated by a public school for children 33 months or older;

273.24 (6) nonresidential programs primarily for children that provide care or supervision for
273.25 periods of less than three hours a day while the child's parent or legal guardian is in the
273.26 same building as the nonresidential program or present within another building that is
273.27 directly contiguous to the building in which the nonresidential program is located;

273.28 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
273.29 under section 245A.02;

274.1 (8) board and lodge facilities licensed by the commissioner of health that do not provide
274.2 children's residential services under Minnesota Rules, chapter 2960, mental health or chemical
274.3 dependency treatment;

274.4 (9) homes providing programs for persons placed by a county or a licensed agency for
274.5 legal adoption, unless the adoption is not completed within two years;

274.6 (10) programs licensed by the commissioner of corrections;

274.7 (11) recreation programs for children or adults that are operated or approved by a park
274.8 and recreation board whose primary purpose is to provide social and recreational activities;

274.9 (12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA
274.10 as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in
274.11 section 315.51, whose primary purpose is to provide child care or services to school-age
274.12 children;

274.13 (13) Head Start nonresidential programs which operate for less than 45 days in each
274.14 calendar year;

274.15 (14) noncertified boarding care homes unless they provide services for five or more
274.16 persons whose primary diagnosis is mental illness or a developmental disability;

274.17 (15) programs for children such as scouting, boys clubs, girls clubs, and sports and art
274.18 programs, and nonresidential programs for children provided for a cumulative total of less
274.19 than 30 days in any 12-month period;

274.20 (16) residential programs for persons with mental illness, that are located in hospitals;

274.21 (17) the religious instruction of school-age children; Sabbath or Sunday schools; or the
274.22 congregate care of children by a church, congregation, or religious society during the period
274.23 used by the church, congregation, or religious society for its regular worship;

274.24 (18) camps licensed by the commissioner of health under Minnesota Rules, chapter
274.25 4630;

274.26 (19) mental health outpatient services for adults with mental illness or children with
274.27 emotional disturbance;

274.28 (20) residential programs serving school-age children whose sole purpose is cultural or
274.29 educational exchange, until the commissioner adopts appropriate rules;

274.30 (21) community support services programs as defined in section 245.462, subdivision
274.31 6, and family community support services as defined in section 245.4871, subdivision 17;

275.1 (22) the placement of a child by a birth parent or legal guardian in a preadoptive home
275.2 for purposes of adoption as authorized by section 259.47;

275.3 (23) settings registered under chapter 144D which provide home care services licensed
275.4 by the commissioner of health to fewer than seven adults;

275.5 (24) ~~chemical dependency or substance abuse~~ use disorder treatment activities of licensed
275.6 professionals in private practice as defined in ~~Minnesota Rules, part 9530.6405, subpart 15,~~
275.7 ~~when the treatment activities are not paid for by the consolidated chemical dependency~~
275.8 ~~treatment fund~~ section 245G.01, subdivision 17;

275.9 (25) consumer-directed community support service funded under the Medicaid waiver
275.10 for persons with developmental disabilities when the individual who provided the service
275.11 is:

275.12 (i) the same individual who is the direct payee of these specific waiver funds or paid by
275.13 a fiscal agent, fiscal intermediary, or employer of record; and

275.14 (ii) not otherwise under the control of a residential or nonresidential program that is
275.15 required to be licensed under this chapter when providing the service;

275.16 (26) a program serving only children who are age 33 months or older, that is operated
275.17 by a nonpublic school, for no more than four hours per day per child, with no more than 20
275.18 children at any one time, and that is accredited by:

275.19 (i) an accrediting agency that is formally recognized by the commissioner of education
275.20 as a nonpublic school accrediting organization; or

275.21 (ii) an accrediting agency that requires background studies and that receives and
275.22 investigates complaints about the services provided.

275.23 A program that asserts its exemption from licensure under item (ii) shall, upon request
275.24 from the commissioner, provide the commissioner with documentation from the accrediting
275.25 agency that verifies: that the accreditation is current; that the accrediting agency investigates
275.26 complaints about services; and that the accrediting agency's standards require background
275.27 studies on all people providing direct contact services; or

275.28 (27) a program operated by a nonprofit organization incorporated in Minnesota or another
275.29 state that serves youth in kindergarten through grade 12; provides structured, supervised
275.30 youth development activities; and has learning opportunities take place before or after
275.31 school, on weekends, or during the summer or other seasonal breaks in the school calendar.
275.32 A program exempt under this clause is not eligible for child care assistance under chapter
275.33 119B. A program exempt under this clause must:

276.1 (i) have a director or supervisor on site who is responsible for overseeing written policies
 276.2 relating to the management and control of the daily activities of the program, ensuring the
 276.3 health and safety of program participants, and supervising staff and volunteers;

276.4 (ii) have obtained written consent from a parent or legal guardian for each youth
 276.5 participating in activities at the site; and

276.6 (iii) have provided written notice to a parent or legal guardian for each youth at the site
 276.7 that the program is not licensed or supervised by the state of Minnesota and is not eligible
 276.8 to receive child care assistance payments.

276.9 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
 276.10 building in which a nonresidential program is located if it shares a common wall with the
 276.11 building in which the nonresidential program is located or is attached to that building by
 276.12 skyway, tunnel, atrium, or common roof.

276.13 (c) Except for the home and community-based services identified in section 245D.03,
 276.14 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
 276.15 provided and funded according to an approved federal waiver plan where licensure is
 276.16 specifically identified as not being a condition for the services and funding.

276.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

276.18 Sec. 8. Minnesota Statutes 2016, section 245A.191, is amended to read:

276.19 **245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL**
 276.20 **DEPENDENCY CONSOLIDATED TREATMENT FUND.**

276.21 (a) When a ~~chemical dependency~~ substance use disorder treatment provider licensed
 276.22 under chapter 245G or Minnesota Rules, parts 2960.0430 to 2960.0490 ~~or 9530.6405 to~~
 276.23 ~~9530.6505~~, agrees to meet the applicable requirements under section 254B.05, subdivision
 276.24 5, ~~paragraphs (b), clauses (1) to (4) and (6), (c), and (e)~~, to be eligible for enhanced funding
 276.25 from the chemical dependency consolidated treatment fund, the applicable requirements
 276.26 under section 254B.05 are also licensing requirements that may be monitored for compliance
 276.27 through licensing investigations and licensing inspections.

276.28 (b) Noncompliance with the requirements identified under paragraph (a) may result in:

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

276.31 (2) nonpayment of claims submitted by the license holder for public program
 276.32 reimbursement;

- 277.1 (3) recovery of payments made for the service;
- 277.2 (4) disenrollment in the public payment program; or
- 277.3 (5) other administrative, civil, or criminal penalties as provided by law.

277.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

277.5 Sec. 9. **[245G.01] DEFINITIONS.**

277.6 **Subdivision 1. Scope.** The terms used in this chapter have the meanings given them.

277.7 **Subd. 2. Administration of medication.** "Administration of medication" means providing
277.8 a medication to a client, and includes the following tasks, performed in the following order:

277.9 (1) checking the client's medication record;

277.10 (2) preparing the medication for administration;

277.11 (3) administering the medication to the client;

277.12 (4) documenting the administration of the medication, or the reason for not administering
277.13 a medication as prescribed; and

277.14 (5) reporting information to a licensed practitioner or a nurse regarding a problem with
277.15 the administration of medication or the client's refusal to take the medication, if applicable.

277.16 **Subd. 3. Adolescent.** "Adolescent" means an individual under 18 years of age.

277.17 **Subd. 4. Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning
277.18 given in section 148F.01, subdivision 5.

277.19 **Subd. 5. Applicant.** "Applicant" means an individual, corporation, partnership, voluntary
277.20 association, controlling individual, or other organization that applied for a license under
277.21 this chapter.

277.22 **Subd. 6. Capacity management system.** "Capacity management system" means a
277.23 database maintained by the department to compile and make information available to the
277.24 public about the waiting list status and current admission capability of each opioid treatment
277.25 program.

277.26 **Subd. 7. Central registry.** "Central registry" means a database maintained by the
277.27 department to collect identifying information from two or more programs about an individual
277.28 applying for maintenance treatment or detoxification treatment for opioid addiction to
277.29 prevent an individual's concurrent enrollment in more than one program.

278.1 Subd. 8. **Client.** "Client" means an individual accepted by a license holder for assessment
278.2 or treatment of a substance use disorder. An individual remains a client until the license
278.3 holder no longer provides or intends to provide the individual with treatment service.

278.4 Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services.

278.5 Subd. 10. **Co-occurring disorders.** "Co-occurring disorders" means a diagnosis of both
278.6 a substance use disorder and a mental health disorder.

278.7 Subd. 11. **Department.** "Department" means the Department of Human Services.

278.8 Subd. 12. **Direct contact.** "Direct contact" has the meaning given for "direct contact"
278.9 in section 245C.02, subdivision 11.

278.10 Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive and visual
278.11 communication between a client and a treatment service provider and includes services
278.12 delivered in person or via telemedicine.

278.13 Subd. 14. **License.** "License" means a certificate issued by the commissioner authorizing
278.14 the license holder to provide a specific program for a specified period of time according to
278.15 the terms of the license and the rules of the commissioner.

278.16 Subd. 15. **License holder.** "License holder" means an individual, corporation, partnership,
278.17 voluntary organization, or other organization that is legally responsible for the operation of
278.18 the program, was granted a license by the commissioner under this chapter, and is a
278.19 controlling individual.

278.20 Subd. 16. **Licensed practitioner.** "Licensed practitioner" means an individual who is
278.21 authorized to prescribe medication as defined in section 151.01, subdivision 23.

278.22 Subd. 17. **Licensed professional in private practice.** "Licensed professional in private
278.23 practice" means an individual who:

278.24 (1) is licensed under chapter 148F, or is exempt from licensure under that chapter but
278.25 is otherwise licensed to provide alcohol and drug counseling services;

278.26 (2) practices solely within the permissible scope of the individual's license as defined
278.27 in the law authorizing licensure; and

278.28 (3) does not affiliate with other licensed or unlicensed professionals to provide alcohol
278.29 and drug counseling services. Affiliation does not include conferring with another
278.30 professional or making a client referral.

279.1 Subd. 18. **Nurse.** "Nurse" means an individual licensed and currently registered to
279.2 practice professional or practical nursing as defined in section 148.171, subdivisions 14 and
279.3 15.

279.4 Subd. 19. **Opioid treatment program or OTP.** "Opioid treatment program" or "OTP"
279.5 means a program or practitioner engaged in opioid treatment of an individual that provides
279.6 dispensing of an opioid agonist treatment medication, along with a comprehensive range
279.7 of medical and rehabilitative services, when clinically necessary, to an individual to alleviate
279.8 the adverse medical, psychological, or physical effects of an opioid addiction. OTP includes
279.9 detoxification treatment, short-term detoxification treatment, long-term detoxification
279.10 treatment, maintenance treatment, comprehensive maintenance treatment, and interim
279.11 maintenance treatment.

279.12 Subd. 20. **Paraprofessional.** "Paraprofessional" means an employee, agent, or
279.13 independent contractor of the license holder who performs tasks to support treatment service.
279.14 A paraprofessional may be referred to by a variety of titles including but not limited to
279.15 technician, case aide, or counselor assistant. If currently a client of the license holder, the
279.16 client cannot be a paraprofessional for the license holder.

279.17 Subd. 21. **Student intern.** "Student intern" means an individual who is authorized by a
279.18 licensing board to provide services under supervision of a licensed professional.

279.19 Subd. 22. **Substance.** "Substance" means alcohol, solvents, controlled substances as
279.20 defined in section 152.01, subdivision 4, and other mood-altering substances.

279.21 Subd. 23. **Substance use disorder.** "Substance use disorder" has the meaning given in
279.22 the current Diagnostic and Statistical Manual of Mental Disorders.

279.23 Subd. 24. **Substance use disorder treatment.** "Substance use disorder treatment" means
279.24 treatment of a substance use disorder, including the process of assessment of a client's needs,
279.25 development of planned methods, including interventions or services to address a client's
279.26 needs, provision of services, facilitation of services provided by other service providers,
279.27 and ongoing reassessment by a qualified professional when indicated. The goal of substance
279.28 use disorder treatment is to assist or support the client's efforts to recover from a substance
279.29 use disorder.

279.30 Subd. 25. **Target population.** "Target population" means individuals with a substance
279.31 use disorder and the specified characteristics that a license holder proposes to serve.

280.1 Subd. 26. **Telemedicine.** "Telemedicine" means the delivery of a substance use disorder
280.2 treatment service while the client is at an originating site and the licensed health care provider
280.3 is at a distant site as specified in section 254B.05, subdivision 5, paragraph (f).

280.4 Subd. 27. **Treatment director.** "Treatment director" means an individual who meets
280.5 the qualifications specified in section 245G.11, subdivisions 1 and 3, and is designated by
280.6 the license holder to be responsible for all aspects of the delivery of treatment service.

280.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

280.8 Sec. 10. **[245G.02] APPLICABILITY.**

280.9 Subdivision 1. **Applicability.** Except as provided in subdivisions 2 and 3, no person,
280.10 corporation, partnership, voluntary association, controlling individual, or other organization
280.11 may provide a substance use disorder treatment service to an individual with a substance
280.12 use disorder unless licensed by the commissioner.

280.13 Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county
280.14 or recovery community organization that is providing a service for which the county or
280.15 recovery community organization is an eligible vendor under section 254B.05. This chapter
280.16 does not apply to an organization whose primary functions are information, referral,
280.17 diagnosis, case management, and assessment for the purposes of client placement, education,
280.18 support group services, or self-help programs. This chapter does not apply to the activities
280.19 of a licensed professional in private practice.

280.20 Subd. 3. **Excluded hospitals.** This chapter does not apply to substance use disorder
280.21 treatment provided by a hospital licensed under chapter 62J, or under sections 144.50 to
280.22 144.56, unless the hospital accepts funds for substance use disorder treatment from the
280.23 consolidated chemical dependency treatment fund under chapter 254B, medical assistance
280.24 under chapter 256B, or MinnesotaCare or health care cost containment under chapter 256L,
280.25 or general assistance medical care formerly codified in chapter 256D.

280.26 Subd. 4. **Applicability of Minnesota Rules, chapter 2960.** A residential adolescent
280.27 substance use disorder treatment program serving an individual younger than 16 years of
280.28 age must be licensed according to Minnesota Rules, chapter 2960.

280.29 **EFFECTIVE DATE.** This section is effective January 1, 2018.

281.1 **Sec. 11. [245G.03] LICENSING REQUIREMENTS.**

281.2 Subdivision 1. License requirements. (a) An applicant for a license to provide substance
281.3 use disorder treatment must comply with the general requirements in chapters 245A and
281.4 245C, sections 626.556 and 626.557, and Minnesota Rules, chapter 9544.

281.5 (b) The commissioner may grant variances to the requirements in this chapter that do
281.6 not affect the client's health or safety if the conditions in section 245A.04, subdivision 9,
281.7 are met.

281.8 Subd. 2. Application. Before the commissioner issues a license, an applicant must
281.9 submit, on forms provided by the commissioner, any documents the commissioner requires
281.10 to demonstrate the following:

281.11 (1) compliance with this chapter;

281.12 (2) compliance with applicable building, fire and safety codes, health rules, zoning
281.13 ordinances, and other applicable rules and regulations or documentation that a waiver was
281.14 granted. An applicant's receipt of a waiver does not constitute modification of any
281.15 requirement in this chapter; and

281.16 (3) insurance coverage, including bonding, sufficient to cover all client funds, property,
281.17 and interests.

281.18 Subd. 3. Change in license terms. (a) The commissioner must determine whether a
281.19 new license is needed when a change in clauses (1) to (4) occurs. A license holder must
281.20 notify the commissioner before a change in one of the following occurs:

281.21 (1) the Department of Health's licensure of the program;

281.22 (2) whether the license holder provides services specified in sections 245G.18 to 245G.22;

281.23 (3) location; or

281.24 (4) capacity if the license holder meets the requirements of section 245G.21.

281.25 (b) A license holder must notify the commissioner and must apply for a new license if
281.26 there is a change in program ownership.

281.27 **EFFECTIVE DATE.** This section is effective January 1, 2018.

281.28 **Sec. 12. [245G.04] INITIAL SERVICES PLAN.**

281.29 (a) The license holder must complete an initial services plan on the day of service
281.30 initiation. The plan must address the client's immediate health and safety concerns, identify

282.1 the needs to be addressed in the first treatment session, and make treatment suggestions for
282.2 the client during the time between intake and completion of the individual treatment plan.

282.3 (b) The initial services plan must include a determination of whether a client is a
282.4 vulnerable adult as defined in section 626.5572, subdivision 21. An adult client of a
282.5 residential program is a vulnerable adult. An individual abuse prevention plan, according
282.6 to sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph
282.7 (b), is required for a client who meets the definition of vulnerable adult.

282.8 **EFFECTIVE DATE.** This section is effective January 1, 2018.

282.9 Sec. 13. **[245G.05] COMPREHENSIVE ASSESSMENT AND ASSESSMENT**
282.10 **SUMMARY.**

282.11 Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the
282.12 client's substance use disorder must be administered face-to-face by an alcohol and drug
282.13 counselor within three calendar days after service initiation for a residential program or
282.14 during the initial session for all other programs. If the comprehensive assessment is not
282.15 completed during the initial session, the client-centered reason for the delay must be
282.16 documented in the client's file and the planned completion date. If the client received a
282.17 comprehensive assessment that authorized the treatment service, an alcohol and drug
282.18 counselor must review the assessment to determine compliance with this subdivision,
282.19 including applicable timelines. If available, the alcohol and drug counselor may use current
282.20 information provided by a referring agency or other source as a supplement. Information
282.21 gathered more than 45 days before the date of admission is not considered current. If the
282.22 comprehensive assessment cannot be completed in the time specified, the treatment plan
282.23 must indicate a person-centered reason for the delay, and how and when the comprehensive
282.24 assessment will be completed. The comprehensive assessment must include sufficient
282.25 information to complete the assessment summary according to subdivision 2 and the
282.26 individual treatment plan according to section 245G.06. The comprehensive assessment
282.27 must include information about the client's needs that relate to substance use and personal
282.28 strengths that support recovery, including:

282.29 (1) age, sex, cultural background, sexual orientation, living situation, economic status,
282.30 and level of education;

282.31 (2) circumstances of service initiation;

282.32 (3) previous attempts at treatment for substance misuse or substance use disorder,
282.33 compulsive gambling, or mental illness;

283.1 (4) substance use history including amounts and types of substances used, frequency
283.2 and duration of use, periods of abstinence, and circumstances of relapse, if any. For each
283.3 substance used within the previous 30 days, the information must include the date of the
283.4 most recent use and previous withdrawal symptoms;

283.5 (5) specific problem behaviors exhibited by the client when under the influence of
283.6 substances;

283.7 (6) family status, family history, including history or presence of physical or sexual
283.8 abuse, level of family support, and substance misuse or substance use disorder of a family
283.9 member or significant other;

283.10 (7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns
283.11 are being addressed by a health care professional;

283.12 (8) mental health history and psychiatric status, including symptoms, disability, current
283.13 treatment supports, and psychotropic medication needed to maintain stability; the assessment
283.14 must utilize screening tools approved by the commissioner pursuant to section 245.4863 to
283.15 identify whether the client screens positive for co-occurring disorders;

283.16 (9) arrests and legal interventions related to substance use;

283.17 (10) ability to function appropriately in work and educational settings;

283.18 (11) ability to understand written treatment materials, including rules and the client's
283.19 rights;

283.20 (12) risk-taking behavior, including behavior that puts the client at risk of exposure to
283.21 blood-borne or sexually transmitted diseases;

283.22 (13) social network in relation to expected support for recovery and leisure time activities
283.23 that are associated with substance use;

283.24 (14) whether the client is pregnant and, if so, the health of the unborn child and the
283.25 client's current involvement in prenatal care;

283.26 (15) whether the client recognizes problems related to substance use and is willing to
283.27 follow treatment recommendations; and

283.28 (16) collateral information. If the assessor gathered sufficient information from the
283.29 referral source or the client to apply the criteria in parts 9530.6620 and 9530.6622, a collateral
283.30 contact is not required.

283.31 (b) If the client is identified as having opioid use disorder or seeking treatment for opioid
283.32 use disorder, the program must provide educational information to the client concerning:

- 284.1 (1) risks for opioid use disorder and dependence;
- 284.2 (2) treatment options, including the use of a medication for opioid use disorder;
- 284.3 (3) the risk of and recognizing opioid overdose; and
- 284.4 (4) the use, availability, and administration of naloxone to respond to opioid overdose.
- 284.5 (c) The commissioner shall develop educational materials that are supported by research
- 284.6 and updated periodically. The license holder must use the educational materials that are
- 284.7 approved by the commissioner to comply with this requirement.
- 284.8 (d) If the comprehensive assessment is completed to authorize treatment service for the
- 284.9 client, at the earliest opportunity during the assessment interview the assessor shall determine
- 284.10 if:
- 284.11 (1) the client is in severe withdrawal and likely to be a danger to self or others;
- 284.12 (2) the client has severe medical problems that require immediate attention; or
- 284.13 (3) the client has severe emotional or behavioral symptoms that place the client or others
- 284.14 at risk of harm.
- 284.15 If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the
- 284.16 assessment interview and follow the procedures in the program's medical services plan
- 284.17 under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The
- 284.18 assessment interview may resume when the condition is resolved.
- 284.19 Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an
- 284.20 assessment summary within three calendar days after service initiation for a residential
- 284.21 program and within three sessions for all other programs. If the comprehensive assessment
- 284.22 is used to authorize the treatment service, the alcohol and drug counselor must prepare an
- 284.23 assessment summary on the same date the comprehensive assessment is completed. If the
- 284.24 comprehensive assessment and assessment summary are to authorize treatment services,
- 284.25 the assessor must determine appropriate services for the client using the dimensions in
- 284.26 Minnesota Rules, part 9530.6622, and document the recommendations.
- 284.27 (b) An assessment summary must include:
- 284.28 (1) a risk description according to section 245G.05 for each dimension listed in paragraph
- 284.29 (c);
- 284.30 (2) a narrative summary supporting the risk descriptions; and
- 284.31 (3) a determination of whether the client has a substance use disorder.

285.1 (c) An assessment summary must contain information relevant to treatment service
285.2 planning and recorded in the dimensions in clauses (1) to (6). The license holder must
285.3 consider:

285.4 (1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with
285.5 withdrawal symptoms and current state of intoxication;

285.6 (2) Dimension 2, biomedical conditions and complications; the degree to which any
285.7 physical disorder of the client would interfere with treatment for substance use, and the
285.8 client's ability to tolerate any related discomfort. The license holder must determine the
285.9 impact of continued chemical use on the unborn child, if the client is pregnant;

285.10 (3) Dimension 3, emotional, behavioral, and cognitive conditions and complications;
285.11 the degree to which any condition or complication is likely to interfere with treatment for
285.12 substance use or with functioning in significant life areas and the likelihood of harm to self
285.13 or others;

285.14 (4) Dimension 4, readiness for change; the support necessary to keep the client involved
285.15 in treatment service;

285.16 (5) Dimension 5, relapse, continued use, and continued problem potential; the degree
285.17 to which the client recognizes relapse issues and has the skills to prevent relapse of either
285.18 substance use or mental health problems; and

285.19 (6) Dimension 6, recovery environment; whether the areas of the client's life are
285.20 supportive of or antagonistic to treatment participation and recovery.

285.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

285.22 Sec. 14. **[245G.06] INDIVIDUAL TREATMENT PLAN.**

285.23 Subdivision 1. **General.** Each client must have an individual treatment plan developed
285.24 by an alcohol and drug counselor within seven days of service initiation for a residential
285.25 program and within three sessions for all other programs. The client must have active, direct
285.26 involvement in selecting the anticipated outcomes of the treatment process and developing
285.27 the treatment plan. The individual treatment plan must be signed by the client and the alcohol
285.28 and drug counselor and document the client's involvement in the development of the plan.
285.29 The plan may be a continuation of the initial services plan required in section 245G.04.
285.30 Treatment planning must include ongoing assessment of client needs. An individual treatment
285.31 plan must be updated based on new information gathered about the client's condition and
285.32 on whether methods identified have the intended effect. A change to the plan must be signed
285.33 by the client and the alcohol and drug counselor. The plan must provide for the involvement

286.1 of the client's family and people selected by the client as important to the success of treatment
286.2 at the earliest opportunity, consistent with the client's treatment needs and written consent.

286.3 Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six
286.4 dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue
286.5 identified in the assessment summary, prioritized according to the client's needs and focus,
286.6 and must include:

286.7 (1) specific methods to address each identified need, including amount, frequency, and
286.8 anticipated duration of treatment service. The methods must be appropriate to the client's
286.9 language, reading skills, cultural background, and strengths;

286.10 (2) resources to refer the client to when the client's needs are to be addressed concurrently
286.11 by another provider; and

286.12 (3) goals the client must reach to complete treatment and terminate services.

286.13 Subd. 3. **Documentation of treatment services; treatment plan review.** (a) A review
286.14 of all treatment services must be documented weekly and include a review of:

286.15 (1) care coordination activities;

286.16 (2) medical and other appointments the client attended;

286.17 (3) issues related to medications that are not documented in the medication administration
286.18 record; and

286.19 (4) issues related to attendance for treatment services, including the reason for any client
286.20 absence from a treatment service.

286.21 (b) A note must be entered immediately following any significant event. A significant
286.22 event is an event that impacts the client's relationship with other clients, staff, the client's
286.23 family, or the client's treatment plan.

286.24 (c) A treatment plan review must be entered in a client's file weekly or after each treatment
286.25 service, whichever is less frequent, by the staff member providing the service. The review
286.26 must indicate the span of time covered by the review and each of the six dimensions listed
286.27 in section 245G.05, subdivision 2, paragraph (c). The review must:

286.28 (1) indicate the date, type, and amount of each treatment service provided and the client's
286.29 response to each service;

286.30 (2) address each goal in the treatment plan and whether the methods to address the goals
286.31 are effective;

- 287.1 (3) include monitoring of any physical and mental health problems;
- 287.2 (4) document the participation of others;
- 287.3 (5) document staff recommendations for changes in the methods identified in the treatment
- 287.4 plan and whether the client agrees with the change; and
- 287.5 (6) include a review and evaluation of the individual abuse prevention plan according
- 287.6 to section 245A.65.
- 287.7 (d) Each entry in a client's record must be accurate, legible, signed, and dated. A late
- 287.8 entry must be clearly labeled "late entry." A correction to an entry must be made in a way
- 287.9 in which the original entry can still be read.
- 287.10 Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a
- 287.11 discharge summary for each client. The summary must be completed within five days of
- 287.12 the client's service termination or within five days from the client's or program's decision
- 287.13 to terminate services, whichever is earlier.
- 287.14 (b) The service discharge summary must be recorded in the six dimensions listed in
- 287.15 section 245G.05, subdivision 2, paragraph (c), and include the following information:
- 287.16 (1) the client's issues, strengths, and needs while participating in treatment, including
- 287.17 services provided;
- 287.18 (2) the client's progress toward achieving each goal identified in the individual treatment
- 287.19 plan;
- 287.20 (3) a risk description according to section 245G.05; and
- 287.21 (4) the reasons for and circumstances of service termination. If a program discharges a
- 287.22 client at staff request, the reason for discharge and the procedure followed for the decision
- 287.23 to discharge must be documented and comply with the program's policies on staff-initiated
- 287.24 client discharge. If a client is discharged at staff request, the program must give the client
- 287.25 crisis and other referrals appropriate for the client's needs and offer assistance to the client
- 287.26 to access the services.
- 287.27 (c) For a client who successfully completes treatment, the summary must also include:
- 287.28 (1) the client's living arrangements at service termination;
- 287.29 (2) continuing care recommendations, including transitions between more or less intense
- 287.30 services, or more frequent to less frequent services, and referrals made with specific attention
- 287.31 to continuity of care for mental health, as needed;

288.1 (3) service termination diagnosis; and

288.2 (4) the client's prognosis.

288.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

288.4 Sec. 15. **[245G.07] TREATMENT SERVICE.**

288.5 Subdivision 1. **Treatment service.** (a) A license holder must offer the following treatment
288.6 services, unless clinically inappropriate and the justifying clinical rationale is documented:

288.7 (1) individual and group counseling to help the client identify and address needs related
288.8 to substance use and develop strategies to avoid harmful substance use after discharge and
288.9 to help the client obtain the services necessary to establish a lifestyle free of the harmful
288.10 effects of substance use disorder;

288.11 (2) client education strategies to avoid inappropriate substance use and health problems
288.12 related to substance use and the necessary lifestyle changes to regain and maintain health.

288.13 Client education must include information on tuberculosis education on a form approved
288.14 by the commissioner, the human immunodeficiency virus according to section 245A.19,
288.15 other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis.

288.16 A licensed alcohol and drug counselor must be present during an educational group;

288.17 (3) a service to help the client integrate gains made during treatment into daily living
288.18 and to reduce the client's reliance on a staff member for support;

288.19 (4) a service to address issues related to co-occurring disorders, including client education
288.20 on symptoms of mental illness, the possibility of comorbidity, and the need for continued
288.21 medication compliance while recovering from substance use disorder. A group must address
288.22 co-occurring disorders, as needed. When treatment for mental health problems is indicated,
288.23 the treatment must be integrated into the client's individual treatment plan;

288.24 (5) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
288.25 services provided one-to-one by an individual in recovery. Peer support services include
288.26 education, advocacy, mentoring through self-disclosure of personal recovery experiences,
288.27 attending recovery and other support groups with a client, accompanying the client to
288.28 appointments that support recovery, assistance accessing resources to obtain housing,
288.29 employment, education, and advocacy services, and nonclinical recovery support to assist
288.30 the transition from treatment into the recovery community; and

289.1 (6) on July 1, 2018, or upon federal approval, whichever is later, care coordination
289.2 provided by an individual who meets the staff qualifications in section 245G.11, subdivision
289.3 7. Care coordination services include:

289.4 (i) assistance in coordination with significant others to help in the treatment planning
289.5 process whenever possible;

289.6 (ii) assistance in coordination with and follow up for medical services as identified in
289.7 the treatment plan;

289.8 (iii) facilitation of referrals to substance use disorder services as indicated by a client's
289.9 medical provider, comprehensive assessment, or treatment plan;

289.10 (iv) facilitation of referrals to mental health services as identified by a client's
289.11 comprehensive assessment or treatment plan;

289.12 (v) assistance with referrals to economic assistance, social services, housing resources,
289.13 and prenatal care according to the client's needs;

289.14 (vi) life skills advocacy and support accessing treatment follow-up, disease management,
289.15 and education services, including referral and linkages to long-term services and supports
289.16 as needed; and

289.17 (vii) documentation of the provision of care coordination services in the client's file.

289.18 (b) A treatment service provided to a client must be provided according to the individual
289.19 treatment plan and must consider cultural differences and special needs of a client.

289.20 Subd. 2. **Additional treatment service.** A license holder may provide or arrange the
289.21 following additional treatment service as a part of the client's individual treatment plan:

289.22 (1) relationship counseling provided by a qualified professional to help the client identify
289.23 the impact of the client's substance use disorder on others and to help the client and persons
289.24 in the client's support structure identify and change behaviors that contribute to the client's
289.25 substance use disorder;

289.26 (2) therapeutic recreation to allow the client to participate in recreational activities
289.27 without the use of mood-altering chemicals and to plan and select leisure activities that do
289.28 not involve the inappropriate use of chemicals;

289.29 (3) stress management and physical well-being to help the client reach and maintain an
289.30 appropriate level of health, physical fitness, and well-being;

289.31 (4) living skills development to help the client learn basic skills necessary for independent
289.32 living;

290.1 (5) employment or educational services to help the client become financially independent;

290.2 (6) socialization skills development to help the client live and interact with others in a
290.3 positive and productive manner; and

290.4 (7) room, board, and supervision at the treatment site to provide the client with a safe
290.5 and appropriate environment to gain and practice new skills.

290.6 Subd. 3. **Counselors.** A treatment service, including therapeutic recreation, must be
290.7 provided by an alcohol and drug counselor according to section 245G.11, unless the
290.8 individual providing the service is specifically qualified according to the accepted credential
290.9 required to provide the service. Therapeutic recreation does not include planned leisure
290.10 activities.

290.11 Subd. 4. **Location of service provision.** The license holder may provide services at any
290.12 of the license holder's licensed locations or at another suitable location including a school,
290.13 government building, medical or behavioral health facility, or social service organization.
290.14 If services are provided off site from the licensed site, the reason for the provision of services
290.15 remotely must be documented.

290.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

290.17 Sec. 16. **[245G.08] MEDICAL SERVICES.**

290.18 Subdivision 1. **Health care services.** An applicant or license holder must maintain a
290.19 complete description of the health care services, nursing services, dietary services, and
290.20 emergency physician services offered by the applicant or license holder.

290.21 Subd. 2. **Procedures.** The applicant or license holder must have written procedures for
290.22 obtaining a medical intervention for a client, that are approved in writing by a physician
290.23 who is licensed under chapter 147, unless:

290.24 (1) the license holder does not provide a service under section 245G.21; and

290.25 (2) a medical intervention is referred to 911, the emergency telephone number, or the
290.26 client's physician.

290.27 Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone
290.28 available for emergency treatment of opioid overdose must have a written standing order
290.29 protocol by a physician who is licensed under chapter 147, that permits the license holder
290.30 to maintain a supply of naloxone on site, and must require staff to undergo specific training
290.31 in administration of naloxone.

291.1 Subd. 4. **Consultation services.** The license holder must have access to and document
291.2 the availability of a licensed mental health professional to provide diagnostic assessment
291.3 and treatment planning assistance.

291.4 Subd. 5. **Administration of medication and assistance with self-medication.** (a) A
291.5 license holder must meet the requirements in this subdivision if a service provided includes
291.6 the administration of medication.

291.7 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
291.8 licensed practitioner or a registered nurse the task of administration of medication or assisting
291.9 with self-medication, must:

291.10 (1) successfully complete a medication administration training program for unlicensed
291.11 personnel through an accredited Minnesota postsecondary educational institution. A staff
291.12 member's completion of the course must be documented in writing and placed in the staff
291.13 member's personnel file;

291.14 (2) be trained according to a formalized training program that is taught by a registered
291.15 nurse and offered by the license holder. The training must include the process for
291.16 administration of naloxone, if naloxone is kept on site. A staff member's completion of the
291.17 training must be documented in writing and placed in the staff member's personnel records;
291.18 or

291.19 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
291.20 registered nurse must be employed or contracted to develop the policies and procedures for
291.21 administration of medication or assisting with self-administration of medication, or both.

291.22 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
291.23 23. The registered nurse's supervision must include, at a minimum, monthly on-site
291.24 supervision or more often if warranted by a client's health needs. The policies and procedures
291.25 must include:

291.26 (1) a provision that a delegation of administration of medication is limited to the
291.27 administration of a medication that is administered orally, topically, or as a suppository, an
291.28 eye drop, an ear drop, or an inhalant;

291.29 (2) a provision that each client's file must include documentation indicating whether
291.30 staff must conduct the administration of medication or the client must self-administer
291.31 medication, or both;

291.32 (3) a provision that a client may carry emergency medication such as nitroglycerin as
291.33 instructed by the client's physician;

292.1 (4) a provision for the client to self-administer medication when a client is scheduled to
292.2 be away from the facility;

292.3 (5) a provision that if a client self-administers medication when the client is present in
292.4 the facility, the client must self-administer medication under the observation of a trained
292.5 staff member;

292.6 (6) a provision that when a license holder serves a client who is a parent with a child,
292.7 the parent may only administer medication to the child under a staff member's supervision;

292.8 (7) requirements for recording the client's use of medication, including staff signatures
292.9 with date and time;

292.10 (8) guidelines for when to inform a nurse of problems with self-administration of
292.11 medication, including a client's failure to administer, refusal of a medication, adverse
292.12 reaction, or error; and

292.13 (9) procedures for acceptance, documentation, and implementation of a prescription,
292.14 whether written, verbal, telephonic, or electronic.

292.15 Subd. 6. **Control of drugs.** A license holder must have and implement written policies
292.16 and procedures developed by a registered nurse that contain:

292.17 (1) a requirement that each drug must be stored in a locked compartment. A Schedule
292.18 II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked
292.19 compartment, permanently affixed to the physical plant or medication cart;

292.20 (2) a system which accounts for all scheduled drugs each shift;

292.21 (3) a procedure for recording the client's use of medication, including the signature of
292.22 the staff member who completed the administration of the medication with the time and
292.23 date;

292.24 (4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

292.25 (5) a statement that only authorized personnel are permitted access to the keys to a locked
292.26 compartment;

292.27 (6) a statement that no legend drug supply for one client shall be given to another client;
292.28 and

292.29 (7) a procedure for monitoring the available supply of naloxone on site, replenishing
292.30 the naloxone supply when needed, and destroying naloxone according to clause (4).

292.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

293.1 Sec. 17. **[245G.09] CLIENT RECORDS.**

293.2 **Subdivision 1. Client records required.** (a) A license holder must maintain a file of
293.3 current and accurate client records on the premises where the treatment service is provided
293.4 or coordinated. For services provided off site, client records must be available at the program
293.5 and adhere to the same clinical and administrative policies and procedures as services
293.6 provided on site. A program using an electronic health record must maintain virtual access
293.7 to client records on the premises where the treatment service is delivered. The content and
293.8 format of client records must be uniform and entries in each record must be signed and
293.9 dated by the staff member making the entry. Client records must be protected against loss,
293.10 tampering, or unauthorized disclosure according to section 254A.09, chapter 13, and Code
293.11 of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and title
293.12 45, parts 160 to 164.

293.13 (b) The program must have a policy and procedure that identifies how the program will
293.14 track and record client attendance at treatment activities, including the date, duration, and
293.15 nature of each treatment service provided to the client.

293.16 **Subd. 2. Record retention.** The client records of a discharged client must be retained
293.17 by a license holder for seven years. A license holder that ceases to provide treatment service
293.18 must retain client records for seven years from the date of facility closure and must notify
293.19 the commissioner of the location of the client records and the name of the individual
293.20 responsible for maintaining the client's records.

293.21 **Subd. 3. Contents.** Client records must contain the following:

293.22 (1) documentation that the client was given information on client rights and
293.23 responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided
293.24 an orientation to the program abuse prevention plan required under section 245A.65,
293.25 subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record
293.26 must contain documentation that the client was provided educational information according
293.27 to section 245G.05, subdivision 1, paragraph (b);

293.28 (2) an initial services plan completed according to section 245G.04;

293.29 (3) a comprehensive assessment completed according to section 245G.05;

293.30 (4) an assessment summary completed according to section 245G.05, subdivision 2;

293.31 (5) an individual abuse prevention plan according to sections 245A.65, subdivision 2,
293.32 and 626.557, subdivision 14, when applicable;

293.33 (6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

294.1 (7) documentation of treatment services and treatment plan review according to section
294.2 245G.06, subdivision 3; and

294.3 (8) a summary at the time of service termination according to section 245G.06,
294.4 subdivision 4.

294.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

294.6 Sec. 18. **[245G.10] STAFF REQUIREMENTS.**

294.7 Subdivision 1. **Treatment director.** A license holder must have a treatment director.

294.8 Subd. 2. **Alcohol and drug counselor supervisor.** A license holder must employ an
294.9 alcohol and drug counselor supervisor who meets the requirements of section 245G.11,
294.10 subdivision 4. An individual may be simultaneously employed as a treatment director,
294.11 alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual
294.12 meets the qualifications for each position. If an alcohol and drug counselor is simultaneously
294.13 employed as an alcohol and drug counselor supervisor or treatment director, that individual
294.14 must be considered a 0.5 full-time equivalent alcohol and drug counselor for staff
294.15 requirements under subdivision 4.

294.16 Subd. 3. **Responsible staff member.** A treatment director must designate a staff member
294.17 who, when present in the facility, is responsible for the delivery of treatment service. A
294.18 license holder must have a designated staff member during all hours of operation. A license
294.19 holder providing room and board and treatment at the same site must have a responsible
294.20 staff member on duty 24 hours a day. The designated staff member must know and understand
294.21 the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

294.22 Subd. 4. **Staff requirement.** It is the responsibility of the license holder to determine
294.23 an acceptable group size based on each client's needs except that treatment services provided
294.24 in a group shall not exceed 16 clients. A counselor in an opioid treatment program must not
294.25 supervise more than 50 clients. The license holder must maintain a record that documents
294.26 compliance with this subdivision.

294.27 Subd. 5. **Medical emergency.** When a client is present, a license holder must have at
294.28 least one staff member on the premises who has a current American Red Cross standard
294.29 first aid certificate or an equivalent certificate and at least one staff member on the premises
294.30 who has a current American Red Cross community, American Heart Association, or
294.31 equivalent CPR certificate. A single staff member with both certifications satisfies this
294.32 requirement.

295.1 **EFFECTIVE DATE.** This section is effective January 1, 2018.

295.2 Sec. 19. **[245G.11] STAFF QUALIFICATIONS.**

295.3 Subdivision 1. **General qualifications.** (a) All staff members who have direct contact
295.4 must be 18 years of age or older. At the time of employment, each staff member must meet
295.5 the qualifications in this subdivision. For purposes of this subdivision, "problematic substance
295.6 use" means a behavior or incident listed by the license holder in the personnel policies and
295.7 procedures according to section 245G.13, subdivision 1, clause (5).

295.8 (b) A treatment director, supervisor, nurse, counselor, student intern, or other professional
295.9 must be free of problematic substance use for at least the two years immediately preceding
295.10 employment and must sign a statement attesting to that fact.

295.11 (c) A paraprofessional, recovery peer, or any other staff member with direct contact
295.12 must be free of problematic substance use for at least one year immediately preceding
295.13 employment and must sign a statement attesting to that fact.

295.14 Subd. 2. **Employment; prohibition on problematic substance use.** A staff member
295.15 with direct contact must be free from problematic substance use as a condition of
295.16 employment, but is not required to sign additional statements. A staff member with direct
295.17 contact who is not free from problematic substance use must be removed from any
295.18 responsibilities that include direct contact for the time period specified in subdivision 1.
295.19 The time period begins to run on the date of the last incident of problematic substance use
295.20 as described in the facility's policies and procedures according to section 245G.13,
295.21 subdivision 1, clause (5).

295.22 Subd. 3. **Treatment directors.** A treatment director must:

295.23 (1) have at least one year of work experience in direct service to an individual with
295.24 substance use disorder or one year of work experience in the management or administration
295.25 of direct service to an individual with substance use disorder;

295.26 (2) have a baccalaureate degree or three years of work experience in administration or
295.27 personnel supervision in human services; and

295.28 (3) know and understand the implications of this chapter, chapter 245A, and sections
295.29 626.556, 626.557, and 626.5572. Demonstration of the treatment director's knowledge must
295.30 be documented in the personnel record.

295.31 Subd. 4. **Alcohol and drug counselor supervisors.** An alcohol and drug counselor
295.32 supervisor must:

296.1 (1) meet the qualification requirements in subdivision 5;

296.2 (2) have three or more years of experience providing individual and group counseling
296.3 to individuals with substance use disorder; and

296.4 (3) know and understand the implications of this chapter and sections 245A.65, 626.556,
296.5 626.557, and 626.5572.

296.6 Subd. 5. **Alcohol and drug counselor qualifications.** (a) An alcohol and drug counselor
296.7 must either be licensed or exempt from licensure under chapter 148F.

296.8 (b) An individual who is exempt from licensure under chapter 148F, must meet one of
296.9 the following additional requirements:

296.10 (1) completion of at least a baccalaureate degree with a major or concentration in social
296.11 work, nursing, sociology, human services, or psychology, or licensure as a registered nurse;
296.12 successful completion of a minimum of 120 hours of classroom instruction in which each
296.13 of the core functions listed in chapter 148F is covered; and successful completion of 440
296.14 hours of supervised experience as an alcohol and drug counselor, either as a student or a
296.15 staff member;

296.16 (2) completion of at least 270 hours of drug counselor training in which each of the core
296.17 functions listed in chapter 148F is covered, and successful completion of 880 hours of
296.18 supervised experience as an alcohol and drug counselor, either as a student or as a staff
296.19 member;

296.20 (3) current certification as an alcohol and drug counselor or alcohol and drug counselor
296.21 reciprocal, through the evaluation process established by the International Certification and
296.22 Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.;

296.23 (4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling
296.24 education from an accredited school or educational program and 880 hours of alcohol and
296.25 drug counseling practicum; or

296.26 (5) employment in a program formerly licensed under Minnesota Rules, parts 9530.5000
296.27 to 9530.6400, and successful completion of 6,000 hours of supervised work experience in
296.28 a licensed program as an alcohol and drug counselor prior to January 1, 2005.

296.29 (c) An alcohol and drug counselor may not provide a treatment service that requires
296.30 professional licensure unless the individual possesses the necessary license. For the purposes
296.31 of enforcing this section, the commissioner has the authority to monitor a service provider's
296.32 compliance with the relevant standards of the service provider's profession and may issue

297.1 licensing actions against the license holder according to sections 245A.05, 245A.06, and
297.2 245A.07, based on the commissioner's determination of noncompliance.

297.3 Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights,
297.4 according to section 148F.165, and staff member responsibilities. A paraprofessional may
297.5 not admit, transfer, or discharge a client but may be responsible for the delivery of treatment
297.6 service according to section 245G.10, subdivision 3.

297.7 Subd. 7. **Care coordination provider qualifications.** (a) Care coordination must be
297.8 provided by qualified staff. An individual is qualified to provide care coordination if the
297.9 individual:

297.10 (1) is skilled in the process of identifying and assessing a wide range of client needs;

297.11 (2) is knowledgeable about local community resources and how to use those resources
297.12 for the benefit of the client;

297.13 (3) has successfully completed 30 hours of classroom instruction on care coordination
297.14 for an individual with substance use disorder;

297.15 (4) has either:

297.16 (i) a bachelor's degree in one of the behavioral sciences or related fields; or

297.17 (ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest
297.18 Indian Council on Addictive Disorders; and

297.19 (5) has at least 2,000 hours of supervised experience working with individuals with
297.20 substance use disorder.

297.21 (b) A care coordinator must receive at least one hour of supervision regarding individual
297.22 service delivery from an alcohol and drug counselor weekly.

297.23 Subd. 8. **Recovery peer qualifications.** A recovery peer must:

297.24 (1) be at least 21 years of age and have a high school diploma or its equivalent;

297.25 (2) have a minimum of one year in recovery from substance use disorder;

297.26 (3) hold a current credential from a certification body approved by the commissioner
297.27 that demonstrates skills and training in the domains of ethics and boundaries, advocacy,
297.28 mentoring and education, and recovery and wellness support; and

297.29 (4) receive ongoing supervision in areas specific to the domains of the recovery peer's
297.30 role by an alcohol and drug counselor or an individual with a certification approved by the
297.31 commissioner.

298.1 Subd. 9. **Volunteers.** A volunteer may provide treatment service when the volunteer is
298.2 supervised and can be seen or heard by a staff member meeting the criteria in subdivision
298.3 4 or 5, but may not practice alcohol and drug counseling unless qualified under subdivision
298.4 5.

298.5 Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible
298.6 for a treatment service performed by a student intern and must review and sign each
298.7 assessment, progress note, and individual treatment plan prepared by a student intern. A
298.8 student intern must receive the orientation and training required in section 245G.13,
298.9 subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be
298.10 students or licensing candidates with time documented to be directly related to the provision
298.11 of treatment services for which the staff are authorized.

298.12 Subd. 11. **Individuals with temporary permit.** (a) An individual with a temporary
298.13 permit from the Board of Behavioral Health and Therapy may provide chemical dependency
298.14 treatment service according to this subdivision.

298.15 (b) An individual with a temporary permit must be supervised by a licensed alcohol and
298.16 drug counselor assigned by the license holder. The supervising licensed alcohol and drug
298.17 counselor must document the amount and type of supervision provided at least on a weekly
298.18 basis. The supervision must relate to the clinical practice.

298.19 (c) An individual with a temporary permit must be supervised by a clinical supervisor
298.20 approved by the Board of Behavioral Health and Therapy. The supervision must be
298.21 documented and meet the requirements of section 148F.04, subdivision 4.

298.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

298.23 Sec. 20. **[245G.12] PROVIDER POLICIES AND PROCEDURES.**

298.24 A license holder must develop a written policies and procedures manual, indexed
298.25 according to section 245A.04, subdivision 14, paragraph (c), that provides staff members
298.26 immediate access to all policies and procedures and provides a client and other authorized
298.27 parties access to all policies and procedures. The manual must contain the following
298.28 materials:

298.29 (1) assessment and treatment planning policies, including screening for mental health
298.30 concerns and treatment objectives related to the client's identified mental health concerns
298.31 in the client's treatment plan;

298.32 (2) policies and procedures regarding HIV according to section 245A.19;

299.1 (3) the license holder's methods and resources to provide information on tuberculosis
 299.2 and tuberculosis screening to each client and to report a known tuberculosis infection
 299.3 according to section 144.4804;

299.4 (4) personnel policies according to section 245G.13;

299.5 (5) policies and procedures that protect a client's rights according to section 245G.15;

299.6 (6) a medical services plan according to section 245G.08;

299.7 (7) emergency procedures according to section 245G.16;

299.8 (8) policies and procedures for maintaining client records according to section 245G.09;

299.9 (9) procedures for reporting the maltreatment of minors according to section 626.556,

299.10 and vulnerable adults according to sections 245A.65, 626.557, and 626.5572;

299.11 (10) a description of treatment services, including the amount and type of services

299.12 provided;

299.13 (11) the methods used to achieve desired client outcomes;

299.14 (12) the hours of operation; and

299.15 (13) the target population served.

299.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

299.17 Sec. 21. **[245G.13] PROVIDER PERSONNEL POLICIES.**

299.18 Subdivision 1. Personnel policy requirements. A license holder must have written

299.19 personnel policies that are available to each staff member. The personnel policies must:

299.20 (1) ensure that staff member retention, promotion, job assignment, or pay are not affected

299.21 by a good faith communication between a staff member and the department, the Department

299.22 of Health, the ombudsman for mental health and developmental disabilities, law enforcement,

299.23 or a local agency for the investigation of a complaint regarding a client's rights, health, or

299.24 safety;

299.25 (2) contain a job description for each staff member position specifying responsibilities,

299.26 degree of authority to execute job responsibilities, and qualification requirements;

299.27 (3) provide for a job performance evaluation based on standards of job performance

299.28 conducted on a regular and continuing basis, including a written annual review;

299.29 (4) describe behavior that constitutes grounds for disciplinary action, suspension, or

299.30 dismissal, including policies that address staff member problematic substance use and the

300.1 requirements of section 245G.11, subdivision 1, policies prohibiting personal involvement
300.2 with a client in violation of chapter 604, and policies prohibiting client abuse described in
300.3 sections 245A.65, 626.556, 626.557, and 626.5572;

300.4 (5) identify how the program will identify whether behaviors or incidents are problematic
300.5 substance use, including a description of how the facility must address:

300.6 (i) receiving treatment for substance use within the period specified for the position in
300.7 the staff qualification requirements, including medication-assisted treatment;

300.8 (ii) substance use that negatively impacts the staff member's job performance;

300.9 (iii) chemical use that affects the credibility of treatment services with a client, referral
300.10 source, or other member of the community;

300.11 (iv) symptoms of intoxication or withdrawal on the job; and

300.12 (v) the circumstances under which an individual who participates in monitoring by the
300.13 health professional services program for a substance use or mental health disorder is able
300.14 to provide services to the program's clients;

300.15 (6) include a chart or description of the organizational structure indicating lines of
300.16 authority and responsibilities;

300.17 (7) include orientation within 24 working hours of starting for each new staff member
300.18 based on a written plan that, at a minimum, must provide training related to the staff member's
300.19 specific job responsibilities, policies and procedures, client confidentiality, HIV minimum
300.20 standards, and client needs; and

300.21 (8) include policies outlining the license holder's response to a staff member with a
300.22 behavior problem that interferes with the provision of treatment service.

300.23 Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member
300.24 has the training described in this subdivision.

300.25 (b) Each staff member must be trained every two years in:

300.26 (1) client confidentiality rules and regulations and client ethical boundaries; and

300.27 (2) emergency procedures and client rights as specified in sections 144.651, 148F.165,
300.28 and 253B.03.

300.29 (c) Annually each staff member with direct contact must be trained on mandatory
300.30 reporting as specified in sections 245A.65, 626.556, 626.5561, 626.557, and 626.5572,

301.1 including specific training covering the license holder's policies for obtaining a release of
301.2 client information.

301.3 (d) Upon employment and annually thereafter, each staff member with direct contact
301.4 must receive training on HIV minimum standards according to section 245A.19.

301.5 (e) A treatment director, supervisor, nurse, or counselor must have a minimum of 12
301.6 hours of training in co-occurring disorders that includes competencies related to philosophy,
301.7 trauma-informed care, screening, assessment, diagnosis and person-centered treatment
301.8 planning, documentation, programming, medication, collaboration, mental health
301.9 consultation, and discharge planning. A new staff member who has not obtained the training
301.10 must complete the training within six months of employment. A staff member may request,
301.11 and the license holder may grant, credit for relevant training obtained before employment,
301.12 which must be documented in the staff member's personnel file.

301.13 Subd. 3. **Personnel files.** The license holder must maintain a separate personnel file for
301.14 each staff member. At a minimum, the personnel file must conform to the requirements of
301.15 this chapter. A personnel file must contain the following:

301.16 (1) a completed application for employment signed by the staff member and containing
301.17 the staff member's qualifications for employment;

301.18 (2) documentation related to the staff member's background study data, according to
301.19 chapter 245C;

301.20 (3) for a staff member who provides psychotherapy services, employer names and
301.21 addresses for the past five years for which the staff member provided psychotherapy services,
301.22 and documentation of an inquiry required by sections 604.20 to 604.205 made to the staff
301.23 member's former employer regarding substantiated sexual contact with a client;

301.24 (4) documentation that the staff member completed orientation and training;

301.25 (5) documentation that the staff member meets the requirements in section 245G.11;

301.26 (6) documentation demonstrating the staff member's compliance with section 245G.08,
301.27 subdivision 3, for a staff member who conducts administration of medication; and

301.28 (7) documentation demonstrating the staff member's compliance with section 245G.18,
301.29 subdivision 2, for a staff member that treats an adolescent client.

301.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

302.1 Sec. 22. **[245G.14] SERVICE INITIATION AND TERMINATION POLICIES.**

302.2 Subdivision 1. Service initiation policy. A license holder must have a written service
302.3 initiation policy containing service initiation preferences that comply with this section and
302.4 Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria.
302.5 The license holder must not initiate services for an individual who does not meet the service
302.6 initiation criteria. The service initiation criteria must be either posted in the area of the
302.7 facility where services for a client are initiated, or given to each interested person upon
302.8 request. Titles of each staff member authorized to initiate services for a client must be listed
302.9 in the services initiation and termination policies.

302.10 Subd. 2. License holder responsibilities. (a) The license holder must have and comply
302.11 with a written protocol for (1) assisting a client in need of care not provided by the license
302.12 holder, and (2) a client who poses a substantial likelihood of harm to the client or others, if
302.13 the behavior is beyond the behavior management capabilities of the staff members.

302.14 (b) A service termination and denial of service initiation that poses an immediate threat
302.15 to the health of any individual or requires immediate medical intervention must be referred
302.16 to a medical facility capable of admitting the client.

302.17 (c) A service termination policy and a denial of service initiation that involves the
302.18 commission of a crime against a license holder's staff member or on a license holder's
302.19 premises, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and
302.20 title 45, parts 160 to 164, must be reported to a law enforcement agency with jurisdiction.

302.21 Subd. 3. Service termination policies. A license holder must have a written policy
302.22 specifying the conditions when a client must be terminated from service. The service
302.23 termination policy must include:

302.24 (1) procedures for a client whose services were terminated under subdivision 2;

302.25 (2) a description of client behavior that constitutes reason for a staff-requested service
302.26 termination and a process for providing this information to a client;

302.27 (3) a requirement that before discharging a client from a residential setting, for not
302.28 reaching treatment plan goals, the license holder must confer with other interested persons
302.29 to review the issues involved in the decision. The documentation requirements for a
302.30 staff-requested service termination must describe why the decision to discharge is warranted,
302.31 the reasons for the discharge, and the alternatives considered or attempted before discharging
302.32 the client;

303.1 (4) procedures consistent with section 253B.16, subdivision 2, that staff members must
 303.2 follow when a client admitted under chapter 253B is to have services terminated;

303.3 (5) procedures a staff member must follow when a client leaves against staff or medical
 303.4 advice and when the client may be dangerous to the client or others, including a policy that
 303.5 requires a staff member to assist the client with assessing needs of care or other resources;

303.6 (6) procedures for communicating staff-approved service termination criteria to a client,
 303.7 including the expectations in the client's individual treatment plan according to section
 303.8 245G.06; and

303.9 (7) titles of each staff member authorized to terminate a client's service must be listed
 303.10 in the service initiation and service termination policies.

303.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

303.12 **Sec. 23. [245G.15] CLIENT RIGHTS PROTECTION.**

303.13 Subdivision 1. **Explanation.** A client has the rights identified in sections 144.651,
 303.14 148F.165, 253B.03, and 254B.02, subdivision 2, as applicable. The license holder must
 303.15 give each client at service initiation a written statement of the client's rights and
 303.16 responsibilities. A staff member must review the statement with a client at that time.

303.17 Subd. 2. **Grievance procedure.** At service initiation, the license holder must explain
 303.18 the grievance procedure to the client or the client's representative. The grievance procedure
 303.19 must be posted in a place visible to clients, and made available upon a client's or former
 303.20 client's request. The grievance procedure must require that:

303.21 (1) a staff member helps the client develop and process a grievance;

303.22 (2) current telephone numbers and addresses of the Department of Human Services,
 303.23 Licensing Division; the Office of Ombudsman for Mental Health and Developmental
 303.24 Disabilities; the Department of Health Office of Health Facilities Complaints; and the Board
 303.25 of Behavioral Health and Therapy, when applicable, be made available to a client; and

303.26 (3) a license holder responds to the client's grievance within three days of a staff member's
 303.27 receipt of the grievance, and the client may bring the grievance to the highest level of
 303.28 authority in the program if not resolved by another staff member.

303.29 Subd. 3. **Photographs of client.** (a) A photograph, video, or motion picture of a client
 303.30 taken in the provision of treatment service is considered client records. A photograph for
 303.31 identification and a recording by video or audio technology to enhance either therapy or
 303.32 staff member supervision may be required of a client, but may only be available for use as

304.1 communications within a program. A client must be informed when the client's actions are
304.2 being recorded by camera or other technology, and the client must have the right to refuse
304.3 any recording or photography, except as authorized by this subdivision.

304.4 (b) A license holder must have a written policy regarding the use of any personal
304.5 electronic device that can record, transmit, or make images of another client. A license
304.6 holder must inform each client of this policy and the client's right to refuse being
304.7 photographed or recorded.

304.8 **EFFECTIVE DATE.** This section is effective January 1, 2018.

304.9 **Sec. 24. [245G.16] BEHAVIORAL EMERGENCY PROCEDURES.**

304.10 (a) A license holder or applicant must have written behavioral emergency procedures
304.11 that staff must follow when responding to a client who exhibits behavior that is threatening
304.12 to the safety of the client or others. Programs must incorporate person-centered planning
304.13 and trauma-informed care in the program's behavioral emergency procedure policies. The
304.14 procedures must include:

304.15 (1) a plan designed to prevent a client from hurting themselves or others;

304.16 (2) contact information for emergency resources that staff must consult when a client's
304.17 behavior cannot be controlled by the behavioral emergency procedures;

304.18 (3) types of procedures that may be used;

304.19 (4) circumstances under which behavioral emergency procedures may be used; and

304.20 (5) staff members authorized to implement behavioral emergency procedures.

304.21 (b) Behavioral emergency procedures must not be used to enforce facility rules or for
304.22 the convenience of staff. Behavioral emergency procedures must not be part of any client's
304.23 treatment plan, or used at any time for any reason except in response to specific current
304.24 behavior that threatens the safety of the client or others. Behavioral emergency procedures
304.25 may not include the use of seclusion or restraint.

304.26 **EFFECTIVE DATE.** This section is effective January 1, 2018.

304.27 **Sec. 25. [245G.17] EVALUATION.**

304.28 A license holder must participate in the drug and alcohol abuse normative evaluation
304.29 system by submitting information about each client to the commissioner in a manner
304.30 prescribed by the commissioner. A license holder must submit additional information

305.1 requested by the commissioner that is necessary to meet statutory or federal funding
305.2 requirements.

305.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

305.4 Sec. 26. **[245G.18] LICENSE HOLDERS SERVING ADOLESCENTS.**

305.5 Subdivision 1. **License.** A residential treatment program that serves an adolescent younger
305.6 than 16 years of age must be licensed as a residential program for a child in out-of-home
305.7 placement by the department unless the license holder is exempt under section 245A.03,
305.8 subdivision 2.

305.9 Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements
305.10 specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing
305.11 treatment service to an adolescent must have:

305.12 (1) an additional 30 hours of classroom instruction or one three-credit semester college
305.13 course in adolescent development. This training need only be completed one time; and

305.14 (2) at least 150 hours of supervised experience as an adolescent counselor, either as a
305.15 student or as a staff member.

305.16 Subd. 3. **Staff ratios.** At least 25 percent of a counselor's scheduled work hours must
305.17 be allocated to indirect services, including documentation of client services, coordination
305.18 of services with others, treatment team meetings, and other duties. A counseling group
305.19 consisting entirely of adolescents must not exceed 16 adolescents. It is the responsibility of
305.20 the license holder to determine an acceptable group size based on the needs of the clients.

305.21 Subd. 4. **Academic program requirements.** A client who is required to attend school
305.22 must be enrolled and attending an educational program that was approved by the Department
305.23 of Education.

305.24 Subd. 5. **Program requirements.** In addition to the requirements specified in the client's
305.25 treatment plan under section 245G.06, programs serving an adolescent must include:

305.26 (1) coordination with the school system to address the client's academic needs;

305.27 (2) when appropriate, a plan that addresses the client's leisure activities without chemical
305.28 use; and

305.29 (3) a plan that addresses family involvement in the adolescent's treatment.

305.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

306.1 Sec. 27. **[245G.19] LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.**

306.2 Subdivision 1. **Health license requirements.** In addition to the requirements of sections
306.3 245G.01 to 245G.17, a license holder that offers supervision of a child of a client is subject
306.4 to the requirements of this section. A license holder providing room and board for a client
306.5 and the client's child must have an appropriate facility license from the Department of
306.6 Health.

306.7 Subd. 2. **Supervision of a child.** "Supervision of a child" means a caregiver is within
306.8 sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can
306.9 intervene to protect the child's health and safety. For a school-age child it means a caregiver
306.10 is available to help and care for the child to protect the child's health and safety.

306.11 Subd. 3. **Policy and schedule required.** A license holder must meet the following
306.12 requirements:

306.13 (1) have a policy and schedule delineating the times and circumstances when the license
306.14 holder is responsible for supervision of a child in the program and when the child's parents
306.15 are responsible for supervision of a child. The policy must explain how the program will
306.16 communicate its policy about supervision of a child responsibility to the parent; and

306.17 (2) have written procedures addressing the actions a staff member must take if a child
306.18 is neglected or abused, including while the child is under the supervision of the child's
306.19 parent.

306.20 Subd. 4. **Additional licensing requirements.** During the times the license holder is
306.21 responsible for the supervision of a child, the license holder must meet the following
306.22 standards:

306.23 (1) child and adult ratios in Minnesota Rules, part 9502.0367;

306.24 (2) day care training in section 245A.50;

306.25 (3) behavior guidance in Minnesota Rules, part 9502.0395;

306.26 (4) activities and equipment in Minnesota Rules, part 9502.0415;

306.27 (5) physical environment in Minnesota Rules, part 9502.0425; and

306.28 (6) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license
306.29 holder has a license from the Department of Health.

306.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

307.1 Sec. 28. **[245G.20] LICENSE HOLDERS SERVING PERSONS WITH**
307.2 **CO-OCCURRING DISORDERS.**

307.3 A license holder specializing in the treatment of a person with co-occurring disorders
307.4 must:

307.5 (1) demonstrate that staff levels are appropriate for treating a client with a co-occurring
307.6 disorder, and that there are adequate staff members with mental health training;

307.7 (2) have continuing access to a medical provider with appropriate expertise in prescribing
307.8 psychotropic medication;

307.9 (3) have a mental health professional available for staff member supervision and
307.10 consultation;

307.11 (4) determine group size, structure, and content considering the special needs of a client
307.12 with a co-occurring disorder;

307.13 (5) have documentation of active interventions to stabilize mental health symptoms
307.14 present in the individual treatment plans and progress notes;

307.15 (6) have continuing documentation of collaboration with continuing care mental health
307.16 providers, and involvement of the providers in treatment planning meetings;

307.17 (7) have available program materials adapted to a client with a mental health problem;

307.18 (8) have policies that provide flexibility for a client who may lapse in treatment or may
307.19 have difficulty adhering to established treatment rules as a result of a mental illness, with
307.20 the goal of helping a client successfully complete treatment; and

307.21 (9) have individual psychotherapy and case management available during treatment
307.22 service.

307.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

307.24 Sec. 29. **[245G.21] REQUIREMENTS FOR LICENSED RESIDENTIAL**
307.25 **TREATMENT.**

307.26 Subdivision 1. **Applicability.** A license holder who provides supervised room and board
307.27 at the licensed program site as a treatment component is defined as a residential program
307.28 according to section 245A.02, subdivision 14, and is subject to this section.

307.29 Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by
307.30 the license holder. The license holder must set and post a notice of visiting rules and hours,
307.31 including both day and evening times. A client's right to receive visitors other than a personal

308.1 physician, religious adviser, county case manager, parole or probation officer, or attorney
308.2 may be subject to visiting hours established by the license holder for all clients. The treatment
308.3 director or designee may impose limitations as necessary for the welfare of a client provided
308.4 the limitation and the reasons for the limitation are documented in the client's file. A client
308.5 must be allowed to receive visits at all reasonable times from the client's personal physician,
308.6 religious adviser, county case manager, parole or probation officer, and attorney.

308.7 Subd. 3. **Client property management.** A license holder who provides room and board
308.8 and treatment services to a client in the same facility, and any license holder that accepts
308.9 client property must meet the requirements for handling client funds and property in section
308.10 245A.04, subdivision 13. License holders:

308.11 (1) may establish policies regarding the use of personal property to ensure that treatment
308.12 activities and the rights of other clients are not infringed upon;

308.13 (2) may take temporary custody of a client's property for violation of a facility policy;

308.14 (3) must retain the client's property for a minimum of seven days after the client's service
308.15 termination if the client does not reclaim property upon service termination, or for a minimum
308.16 of 30 days if the client does not reclaim property upon service termination and has received
308.17 room and board services from the license holder; and

308.18 (4) must return all property held in trust to the client at service termination regardless
308.19 of the client's service termination status, except that:

308.20 (i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section
308.21 609.5316, must be given to the custody of a local law enforcement agency. If giving the
308.22 property to the custody of a local law enforcement agency violates Code of Federal
308.23 Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug
308.24 paraphernalia, or drug container must be destroyed by a staff member designated by the
308.25 program director; and

308.26 (ii) a weapon, explosive, and other property that can cause serious harm to the client or
308.27 others must be given to the custody of a local law enforcement agency, and the client must
308.28 be notified of the transfer and of the client's right to reclaim any lawful property transferred;
308.29 and

308.30 (iii) a medication that was determined by a physician to be harmful after examining the
308.31 client must be destroyed, except when the client's personal physician approves the medication
308.32 for continued use.

309.1 Subd. 4. **Health facility license.** A license holder who provides room and board and
309.2 treatment services in the same facility must have the appropriate license from the Department
309.3 of Health.

309.4 Subd. 5. **Facility abuse prevention plan.** A license holder must establish and enforce
309.5 an ongoing facility abuse prevention plan consistent with sections 245A.65 and 626.557,
309.6 subdivision 14.

309.7 Subd. 6. **Individual abuse prevention plan.** A license holder must prepare an individual
309.8 abuse prevention plan for each client as specified under sections 245A.65, subdivision 2,
309.9 and 626.557, subdivision 14.

309.10 Subd. 7. **Health services.** A license holder must have written procedures for assessing
309.11 and monitoring a client's health, including a standardized data collection tool for collecting
309.12 health-related information about each client. The policies and procedures must be approved
309.13 and signed by a registered nurse.

309.14 Subd. 8. **Administration of medication.** A license holder must meet the administration
309.15 of medications requirements of section 245G.08, subdivision 5, if services include medication
309.16 administration.

309.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

309.18 Sec. 30. **[245G.22] OPIOID TREATMENT PROGRAMS.**

309.19 Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed
309.20 under this chapter must also comply with the requirements of this section and Code of
309.21 Federal Regulations, title 42, part 8. When federal guidance or interpretations are issued on
309.22 federal standards or requirements also required under this section, the federal guidance or
309.23 interpretations shall apply.

309.24 (b) Where a standard in this section differs from a standard in an otherwise applicable
309.25 administrative rule or statute, the standard of this section applies.

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

309.28 (b) "Diversion" means the use of a medication for the treatment of opioid addiction being
309.29 diverted from intended use of the medication.

309.30 (c) "Guest dose" means administration of a medication used for the treatment of opioid
309.31 addiction to a person who is not a client of the program that is administering or dispensing
309.32 the medication.

310.1 (d) "Medical director" means a physician licensed to practice medicine in the jurisdiction
310.2 that the opioid treatment program is located who assumes responsibility for administering
310.3 all medical services performed by the program, either by performing the services directly
310.4 or by delegating specific responsibility to authorized program physicians and health care
310.5 professionals functioning under the medical director's direct supervision.

310.6 (e) "Medication used for the treatment of opioid use disorder" means a medication
310.7 approved by the Food and Drug Administration for the treatment of opioid use disorder.

310.8 (f) "Minnesota health care programs" has the meaning given in section 256B.0636.

310.9 (g) "Opioid treatment program" has the meaning given in Code of Federal Regulations,
310.10 title 42, section 8.12, and includes programs licensed under this chapter.

310.11 (h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605,
310.12 subpart 21a.

310.13 (i) "Unsupervised use" means the use of a medication for the treatment of opioid use
310.14 disorder dispensed for use by a client outside of the program setting.

310.15 Subd. 3. **Medication orders.** Before the program may administer or dispense a medication
310.16 used for the treatment of opioid use disorder:

310.17 (1) a client-specific order must be received from an appropriately credentialed physician
310.18 who is enrolled as a Minnesota health care programs provider and meets all applicable
310.19 provider standards;

310.20 (2) the signed order must be documented in the client's record; and

310.21 (3) if the physician that issued the order is not able to sign the order when issued, the
310.22 unsigned order must be entered in the client record at the time it was received, and the
310.23 physician must review the documentation and sign the order in the client's record within 72
310.24 hours of the medication being ordered. The license holder must report to the commissioner
310.25 any medication error that endangers a client's health, as determined by the medical director.

310.26 Subd. 4. **High dose requirements.** A client being administered or dispensed a dose
310.27 beyond that set forth in subdivision 6, paragraph (a), clause (1), that exceeds 150 milligrams
310.28 of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase,
310.29 must meet face-to-face with a prescribing physician. The meeting must occur before the
310.30 administration or dispensing of the increased medication dose.

310.31 Subd. 5. **Drug testing.** Each client enrolled in the program must receive a minimum of
310.32 eight random drug abuse tests per 12 months of treatment. Drug abuse tests must be

311.1 reasonably disbursed over the 12-month period. A license holder may elect to conduct more
311.2 drug abuse tests.

311.3 Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of
311.4 medication used for the treatment of opioid use disorder to the illicit market, medication
311.5 dispensed to a client for unsupervised use shall be subject to the following requirements:

311.6 (1) any client in an opioid treatment program may receive a single unsupervised use
311.7 dose for a day that the clinic is closed for business, including Sundays and state and federal
311.8 holidays; and

311.9 (2) other treatment program decisions on dispensing medications used for the treatment
311.10 of opioid use disorder to a client for unsupervised use shall be determined by the medical
311.11 director.

311.12 (b) In determining whether a client may be permitted unsupervised use of medications,
311.13 a physician with authority to prescribe must consider the criteria in this paragraph. The
311.14 criteria in this paragraph must also be considered when determining whether dispensing
311.15 medication for a client's unsupervised use is appropriate to increase or to extend the amount
311.16 of time between visits to the program. The criteria are:

311.17 (1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics,
311.18 and alcohol;

311.19 (2) regularity of program attendance;

311.20 (3) absence of serious behavioral problems at the program;

311.21 (4) absence of known recent criminal activity such as drug dealing;

311.22 (5) stability of the client's home environment and social relationships;

311.23 (6) length of time in comprehensive maintenance treatment;

311.24 (7) reasonable assurance that unsupervised use medication will be safely stored within
311.25 the client's home; and

311.26 (8) whether the rehabilitative benefit the client derived from decreasing the frequency
311.27 of program attendance outweighs the potential risks of diversion or unsupervised use.

311.28 (c) The determination, including the basis of the determination must be documented in
311.29 the client's medical record.

311.30 Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a
311.31 physician with authority to prescribe determines that a client meets the criteria in subdivision

312.1 6 and may be dispensed a medication used for the treatment of opioid addiction, the
312.2 restrictions in this subdivision must be followed when the medication to be dispensed is
312.3 methadone hydrochloride.

312.4 (b) During the first 90 days of treatment, the unsupervised use medication supply must
312.5 be limited to a maximum of a single dose each week and the client shall ingest all other
312.6 doses under direct supervision.

312.7 (c) In the second 90 days of treatment, the unsupervised use medication supply must be
312.8 limited to two doses per week.

312.9 (d) In the third 90 days of treatment, the unsupervised use medication supply must not
312.10 exceed three doses per week.

312.11 (e) In the remaining months of the first year, a client may be given a maximum six-day
312.12 unsupervised use medication supply.

312.13 (f) After one year of continuous treatment, a client may be given a maximum two-week
312.14 unsupervised use medication supply.

312.15 (g) After two years of continuous treatment, a client may be given a maximum one-month
312.16 unsupervised use medication supply, but must make monthly visits to the program.

312.17 Subd. 8. **Restriction exceptions.** When a license holder has reason to accelerate the
312.18 number of unsupervised use doses of methadone hydrochloride, the license holder must
312.19 comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the
312.20 criteria for unsupervised use and must use the exception process provided by the federal
312.21 Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the
312.22 purposes of enforcement of this subdivision, the commissioner has the authority to monitor
312.23 a program for compliance with federal regulations and may issue licensing actions according
312.24 to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of
312.25 noncompliance.

312.26 Subd. 9. **Guest dose.** To receive a guest dose, the client must be enrolled in an opioid
312.27 treatment program elsewhere in the state or country and be receiving the medication on a
312.28 temporary basis because the client is not able to receive the medication at the program in
312.29 which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any
312.30 one program and must not be for the convenience or benefit of either program. A guest dose
312.31 may also occur when the client's primary clinic is not open and the client is not receiving
312.32 unsupervised use doses.

313.1 Subd. 10. **Capacity management and waiting list system compliance.** An opioid
313.2 treatment program must notify the department within seven days of the program reaching
313.3 both 90 and 100 percent of the program's capacity to care for clients. Each week, the program
313.4 must report its capacity, currently enrolled dosing clients, and any waiting list. A program
313.5 reporting 90 percent of capacity must also notify the department when the program's census
313.6 increases or decreases from the 90 percent level.

313.7 Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system.
313.8 If the person seeking admission cannot be admitted within 14 days of the date of application,
313.9 each person seeking admission must be placed on the waiting list, unless the person seeking
313.10 admission is assessed by the program and found ineligible for admission according to this
313.11 chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and
313.12 title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each
313.13 person seeking treatment while awaiting admission. A person seeking admission on a waiting
313.14 list who receives no services under section 245G.07, subdivision 1, must not be considered
313.15 a client as defined in section 245G.01, subdivision 9.

313.16 Subd. 12. **Client referral.** An opioid treatment program must consult the capacity
313.17 management system to ensure that a person on a waiting list is admitted at the earliest time
313.18 to a program providing appropriate treatment within a reasonable geographic area. If the
313.19 client was referred through a public payment system and if the program is not able to serve
313.20 the client within 14 days of the date of application for admission, the program must contact
313.21 and inform the referring agency of any available treatment capacity listed in the state capacity
313.22 management system.

313.23 Subd. 13. **Outreach.** An opioid treatment program must carry out activities to encourage
313.24 an individual in need of treatment to undergo treatment. The program's outreach model
313.25 must:

313.26 (1) select, train, and supervise outreach workers;

313.27 (2) contact, communicate, and follow up with individuals with high-risk substance
313.28 misuse, individuals with high-risk substance misuse associates, and neighborhood residents
313.29 within the constraints of federal and state confidentiality requirements;

313.30 (3) promote awareness among individuals who engage in substance misuse by injection
313.31 about the relationship between injecting substances and communicable diseases such as
313.32 HIV; and

313.33 (4) recommend steps to prevent HIV transmission.

314.1 Subd. 14. **Central registry.** (a) A license holder must comply with requirements to
314.2 submit information and necessary consents to the state central registry for each client
314.3 admitted, as specified by the commissioner. The license holder must submit data concerning
314.4 medication used for the treatment of opioid use disorder. The data must be submitted in a
314.5 method determined by the commissioner and the original information must be kept in the
314.6 client's record. The information must be submitted for each client at admission and discharge.
314.7 The program must document the date the information was submitted. The client's failure to
314.8 provide the information shall prohibit participation in an opioid treatment program. The
314.9 information submitted must include the client's:

314.10 (1) full name and all aliases;

314.11 (2) date of admission;

314.12 (3) date of birth;

314.13 (4) Social Security number or Alien Registration Number, if any;

314.14 (5) current or previous enrollment status in another opioid treatment program;

314.15 (6) government-issued photo identification card number; and

314.16 (7) driver's license number, if any.

314.17 (b) The requirements in paragraph (a) are effective upon the commissioner's
314.18 implementation of changes to the drug and alcohol abuse normative evaluation system or
314.19 development of an electronic system by which to submit the data.

314.20 Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must
314.21 offer at least 50 consecutive minutes of individual or group therapy treatment services as
314.22 defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first
314.23 ten weeks following admission, and at least 50 consecutive minutes per month thereafter.
314.24 As clinically appropriate, the program may offer these services cumulatively and not
314.25 consecutively in increments of no less than 15 minutes over the required time period, and
314.26 for a total of 60 minutes of treatment services over the time period, and must document the
314.27 reason for providing services cumulatively in the client's record. The program may offer
314.28 additional levels of service when deemed clinically necessary.

314.29 (b) Notwithstanding the requirements of comprehensive assessments in section 245G.05,
314.30 the assessment must be completed within 21 days of service initiation.

314.31 (c) Notwithstanding the requirements of individual treatment plans set forth in section
314.32 245G.06:

315.1 (1) treatment plan contents for a maintenance client are not required to include goals
315.2 the client must reach to complete treatment and have services terminated;

315.3 (2) treatment plans for a client in a taper or detox status must include goals the client
315.4 must reach to complete treatment and have services terminated;

315.5 (3) for the initial ten weeks after admission for all new admissions, readmissions, and
315.6 transfers, progress notes must be entered in a client's file at least weekly and be recorded
315.7 in each of the six dimensions upon the development of the treatment plan and thereafter.
315.8 Subsequently, the counselor must document progress in the six dimensions at least once
315.9 monthly or, when clinical need warrants, more frequently; and

315.10 (4) upon the development of the treatment plan and thereafter, treatment plan reviews
315.11 must occur weekly, or after each treatment service, whichever is less frequent, for the first
315.12 ten weeks after the treatment plan is developed. Following the first ten weeks of treatment
315.13 plan reviews, reviews may occur monthly, unless the client's needs warrant more frequent
315.14 revisions or documentation.

315.15 Subd. 16. **Prescription monitoring program.** (a) The program must develop and
315.16 maintain a policy and procedure that requires the ongoing monitoring of the data from the
315.17 prescription monitoring program (PMP) for each client. The policy and procedure must
315.18 include how the program meets the requirements in paragraph (b).

315.19 (b) If a medication used for the treatment of substance use disorder is administered or
315.20 dispensed to a client, the license holder shall be subject to the following requirements:

315.21 (1) upon admission to a methadone clinic outpatient treatment program, a client must
315.22 be notified in writing that the commissioner of human services and the medical director
315.23 must monitor the PMP to review the prescribed controlled drugs a client received;

315.24 (2) the medical director or the medical director's delegate must review the data from the
315.25 PMP described in section 152.126 before the client is ordered any controlled substance, as
315.26 defined under section 152.126, subdivision 1, paragraph (c), including medications used
315.27 for the treatment of opioid addiction, and the medical director's or the medical director's
315.28 delegate's subsequent reviews of the PMP data must occur at least every 90 days;

315.29 (3) a copy of the PMP data reviewed must be maintained in the client's file;

315.30 (4) when the PMP data contains a recent history of multiple prescribers or multiple
315.31 prescriptions for controlled substances, the physician's review of the data and subsequent
315.32 actions must be documented in the client's file within 72 hours and must contain the medical
315.33 director's determination of whether or not the prescriptions place the client at risk of harm

316.1 and the actions to be taken in response to the PMP findings. The provider must conduct
316.2 subsequent reviews of the PMP on a monthly basis; and

316.3 (5) if at any time the medical director believes the use of the controlled substances places
316.4 the client at risk of harm, the program must seek the client's consent to discuss the client's
316.5 opioid treatment with other prescribers and must seek the client's consent for the other
316.6 prescriber to disclose to the opioid treatment program's medical director the client's condition
316.7 that formed the basis of the other prescriptions. If the information is not obtained within
316.8 seven days, the medical director must document whether or not changes to the client's
316.9 medication dose or number of unsupervised use doses are necessary until the information
316.10 is obtained.

316.11 (c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop
316.12 and implement an electronic system for the commissioner to routinely access the PMP data
316.13 to determine whether any client enrolled in an opioid addiction treatment program licensed
316.14 according to this section was prescribed or dispensed a controlled substance in addition to
316.15 that administered or dispensed by the opioid addiction treatment program. When the
316.16 commissioner determines there have been multiple prescribers or multiple prescriptions of
316.17 controlled substances for a client, the commissioner shall:

316.18 (1) inform the medical director of the opioid treatment program only that the
316.19 commissioner determined the existence of multiple prescribers or multiple prescriptions of
316.20 controlled substances; and

316.21 (2) direct the medical director of the opioid treatment program to access the data directly,
316.22 review the effect of the multiple prescribers or multiple prescriptions, and document the
316.23 review.

316.24 (d) If determined necessary, the commissioner shall seek a federal waiver of, or exception
316.25 to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), before
316.26 implementing this subdivision.

316.27 Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the
316.28 policies and procedures required in this subdivision.

316.29 (b) For a program that is not open every day of the year, the license holder must maintain
316.30 a policy and procedure that permits a client to receive a single unsupervised use of medication
316.31 used for the treatment of opioid use disorder for days that the program is closed for business,
316.32 including, but not limited to, Sundays and state and federal holidays as required under
316.33 subdivision 6, paragraph (a), clause (1).

317.1 (c) The license holder must maintain a policy and procedure that includes specific
317.2 measures to reduce the possibility of diversion. The policy and procedure must:

317.3 (1) specifically identify and define the responsibilities of the medical and administrative
317.4 staff for performing diversion control measures; and

317.5 (2) include a process for contacting no less than five percent of clients who have
317.6 unsupervised use of medication, excluding clients approved solely under subdivision 6,
317.7 paragraph (a), clause (1), to require clients to physically return to the program each month.
317.8 The system must require clients to return to the program within a stipulated time frame and
317.9 turn in all unused medication containers related to opioid use disorder treatment. The license
317.10 holder must document all related contacts on a central log and the outcome of the contact
317.11 for each client in the client's record.

317.12 (d) Medication used for the treatment of opioid use disorder must be ordered,
317.13 administered, and dispensed according to applicable state and federal regulations and the
317.14 standards set by applicable accreditation entities. If a medication order requires assessment
317.15 by the person administering or dispensing the medication to determine the amount to be
317.16 administered or dispensed, the assessment must be completed by an individual whose
317.17 professional scope of practice permits an assessment. For the purposes of enforcement of
317.18 this paragraph, the commissioner has the authority to monitor the person administering or
317.19 dispensing the medication for compliance with state and federal regulations and the relevant
317.20 standards of the license holder's accreditation agency and may issue licensing actions
317.21 according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's
317.22 determination of noncompliance.

317.23 Subd. 18. **Quality improvement plan.** The license holder must develop and maintain
317.24 a quality improvement plan that:

317.25 (1) includes evaluation of the services provided to clients to identify issues that may
317.26 improve service delivery and client outcomes;

317.27 (2) includes goals for the program to accomplish based on the evaluation;

317.28 (3) is reviewed annually by the management of the program to determine whether the
317.29 goals were met and, if not, whether additional action is required;

317.30 (4) is updated at least annually to include new or continued goals based on an updated
317.31 evaluation of services; and

317.32 (5) identifies two specific goal areas, in addition to others identified by the program,
317.33 including:

318.1 (i) a goal concerning oversight and monitoring of the premises around and near the
318.2 exterior of the program to reduce the possibility of medication used for the treatment of
318.3 opioid use disorder being inappropriately used by a client, including but not limited to the
318.4 sale or transfer of the medication to others; and

318.5 (ii) a goal concerning community outreach, including but not limited to communications
318.6 with local law enforcement and county human services agencies, to increase coordination
318.7 of services and identification of areas of concern to be addressed in the plan.

318.8 Subd. 19. **Placing authorities.** A program must provide certain notification and
318.9 client-specific updates to placing authorities for a client who is enrolled in Minnesota health
318.10 care programs. At the request of the placing authority, the program must provide
318.11 client-specific updates, including but not limited to informing the placing authority of
318.12 positive drug screenings and changes in medications used for the treatment of opioid use
318.13 disorder ordered for the client.

318.14 Subd. 20. **Duty to report suspected drug diversion.** (a) To the fullest extent permitted
318.15 under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to
318.16 law enforcement any credible evidence that the program or its personnel knows, or reasonably
318.17 should know, that is directly related to a diversion crime on the premises of the program,
318.18 or a threat to commit a diversion crime.

318.19 (b) "Diversion crime," for the purposes of this section, means diverting, attempting to
318.20 divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02,
318.21 on the program's premises.

318.22 (c) The program must document the program's compliance with the requirement in
318.23 paragraph (a) in either a client's record or an incident report. A program's failure to comply
318.24 with paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

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

318.26 Sec. 31. Minnesota Statutes 2016, section 254A.01, is amended to read:

318.27 **254A.01 PUBLIC POLICY.**

318.28 It is hereby declared to be the public policy of this state that scientific evidence shows
318.29 that addiction to alcohol or other drugs is a chronic brain disorder with potential for
318.30 recurrence, and as with many other chronic conditions, people with substance use disorders
318.31 can be effectively treated and can enter recovery. The interests of society are best served
318.32 by reducing the stigma of substance use disorder and providing persons who are dependent
318.33 upon alcohol or other drugs with a comprehensive range of rehabilitative and social services

319.1 that span intensity levels and are not restricted to a particular point in time. Further, it is
 319.2 declared that treatment under these services shall be voluntary when possible: treatment
 319.3 shall not be denied on the basis of prior treatment; treatment shall be based on an individual
 319.4 treatment plan for each person undergoing treatment; treatment shall include a continuum
 319.5 of services available for a person leaving a program of treatment; treatment shall include
 319.6 all family members at the earliest possible phase of the treatment process.

319.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

319.8 Sec. 32. Minnesota Statutes 2016, section 254A.02, subdivision 2, is amended to read:

319.9 Subd. 2. **Approved treatment program.** "Approved treatment program" means care
 319.10 and treatment services provided by any individual, organization or association to ~~drug~~
 319.11 ~~dependent~~ persons with a substance use disorder, which meets the standards established by
 319.12 the commissioner of human services.

319.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

319.14 Sec. 33. Minnesota Statutes 2016, section 254A.02, subdivision 3, is amended to read:

319.15 Subd. 3. **Comprehensive program.** "Comprehensive program" means the range of
 319.16 services which are to be made available for the purpose of prevention, care and treatment
 319.17 of ~~alcohol and drug abuse~~ substance misuse and substance use disorder.

319.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

319.19 Sec. 34. Minnesota Statutes 2016, section 254A.02, subdivision 5, is amended to read:

319.20 Subd. 5. **Drug dependent person.** "Drug dependent person" means any ~~inebriate person~~
 319.21 ~~or any~~ person incapable of self-management or management of personal affairs or unable
 319.22 to function physically or mentally in an effective manner because of the abuse of a drug,
 319.23 including alcohol.

319.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

319.25 Sec. 35. Minnesota Statutes 2016, section 254A.02, subdivision 6, is amended to read:

319.26 Subd. 6. **Facility.** "Facility" means any treatment facility administered under an approved
 319.27 treatment program ~~established under Laws 1973, chapter 572.~~

319.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

320.1 Sec. 36. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision
320.2 to read:

320.3 Subd. 6a. **Substance misuse.** "Substance misuse" means the use of any psychoactive
320.4 or mood-altering substance, without compelling medical reason, in a manner that results in
320.5 mental, emotional, or physical impairment and causes socially dysfunctional or socially
320.6 disordering behavior and that results in psychological dependence or physiological addiction
320.7 as a function of continued use. Substance misuse has the same meaning as drug abuse or
320.8 abuse of drugs.

320.9 **EFFECTIVE DATE.** This section is effective January 1, 2018.

320.10 Sec. 37. Minnesota Statutes 2016, section 254A.02, subdivision 8, is amended to read:

320.11 Subd. 8. **Other drugs.** "Other drugs" means any psychoactive ~~chemical~~ substance other
320.12 than alcohol.

320.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

320.14 Sec. 38. Minnesota Statutes 2016, section 254A.02, subdivision 10, is amended to read:

320.15 Subd. 10. **State authority.** "State authority" is a division established within the
320.16 Department of Human Services for the purpose of relating the authority of state government
320.17 in the area of ~~alcohol and drug abuse~~ substance misuse and substance use disorder to the
320.18 ~~alcohol and drug abuse~~ substance misuse and substance use disorder-related activities within
320.19 the state.

320.20 **EFFECTIVE DATE.** This section is effective January 1, 2018.

320.21 Sec. 39. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision
320.22 to read:

320.23 Subd. 10a. **Substance use disorder.** "Substance use disorder" has the meaning given
320.24 in the current Diagnostic and Statistical Manual of Mental Disorders.

320.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

320.26 Sec. 40. Minnesota Statutes 2016, section 254A.03, is amended to read:

320.27 **254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.**

320.28 Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an
320.29 Alcohol and Other Drug Abuse Section in the Department of Human Services. This section

321.1 shall be headed by a director. The commissioner may place the director's position in the
321.2 unclassified service if the position meets the criteria established in section 43A.08,
321.3 subdivision 1a. The section shall:

321.4 (1) conduct and foster basic research relating to the cause, prevention and methods of
321.5 diagnosis, treatment and rehabilitation of ~~alcoholic and other drug dependent~~ persons with
321.6 substance misuse and substance use disorder;

321.7 (2) coordinate and review all activities and programs of all the various state departments
321.8 as they relate to ~~alcohol and other drug dependency and abuse~~ problems associated with
321.9 substance misuse and substance use disorder;

321.10 (3) develop, demonstrate, and disseminate new methods and techniques for the prevention,
321.11 early intervention, treatment and ~~rehabilitation of alcohol and other drug abuse and~~
321.12 ~~dependency problems~~ recovery support for substance misuse and substance use disorder;

321.13 (4) gather facts and information about ~~alcoholism and other drug dependency and abuse~~
321.14 substance misuse and substance use disorder, and about the efficiency and effectiveness of
321.15 prevention, treatment, and ~~rehabilitation~~ recovery support services from all comprehensive
321.16 programs, including programs approved or licensed by the commissioner of human services
321.17 or the commissioner of health or accredited by the Joint Commission on Accreditation of
321.18 Hospitals. The state authority is authorized to require information from comprehensive
321.19 programs which is reasonable and necessary to fulfill these duties. When required information
321.20 has been previously furnished to a state or local governmental agency, the state authority
321.21 shall collect the information from the governmental agency. The state authority shall
321.22 disseminate facts and summary information about ~~alcohol and other drug abuse dependency~~
321.23 ~~problems associated with~~ substance misuse and substance use disorder to public and private
321.24 agencies, local governments, local and regional planning agencies, and the courts for guidance
321.25 to and assistance in prevention, treatment and ~~rehabilitation~~ recovery support;

321.26 (5) inform and educate the general public on ~~alcohol and other drug dependency and~~
321.27 ~~abuse problems~~ substance misuse and substance use disorder;

321.28 (6) serve as the state authority concerning ~~alcohol and other drug dependency and abuse~~
321.29 substance misuse and substance use disorder by monitoring the conduct of diagnosis and
321.30 referral services, research and comprehensive programs. The state authority shall submit a
321.31 biennial report to the governor and the legislature containing a description of public services
321.32 delivery and recommendations concerning increase of coordination and quality of services,
321.33 and decrease of service duplication and cost;

322.1 (7) establish a state plan which shall set forth goals and priorities for a comprehensive
 322.2 ~~alcohol and other drug dependency and abuse program~~ continuum of care for substance
 322.3 misuse and substance use disorder for Minnesota. All state agencies operating ~~alcohol and~~
 322.4 ~~other drug abuse or dependency~~ substance misuse or substance use disorder programs or
 322.5 administering state or federal funds for such programs shall annually set their program goals
 322.6 and priorities in accordance with the state plan. Each state agency shall annually submit its
 322.7 plans and budgets to the state authority for review. The state authority shall certify whether
 322.8 proposed services comply with the comprehensive state plan and advise each state agency
 322.9 of review findings;

322.10 (8) make contracts with and grants to public and private agencies and organizations,
 322.11 both profit and nonprofit, and individuals, using federal funds, and state funds as authorized
 322.12 to pay for costs of state administration, including evaluation, statewide programs and services,
 322.13 research and demonstration projects, and American Indian programs;

322.14 (9) receive and administer ~~monies~~ money available for ~~alcohol and drug abuse~~ substance
 322.15 misuse and substance use disorder programs under the alcohol, drug abuse, and mental
 322.16 health services block grant, United States Code, title 42, sections 300X to 300X-9;

322.17 (10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter
 322.18 572, and any grant of money, services, or property from the federal government, the state,
 322.19 any political subdivision thereof, or any private source;

322.20 (11) with respect to ~~alcohol and other drug abuse~~ substance misuse and substance use
 322.21 disorder programs serving the American Indian community, establish guidelines for the
 322.22 employment of personnel with considerable practical experience in ~~alcohol and other drug~~
 322.23 ~~abuse problems~~ substance misuse and substance use disorder, and understanding of social
 322.24 and cultural problems related to ~~alcohol and other drug abuse~~ substance misuse and substance
 322.25 use disorder, in the American Indian community.

322.26 Subd. 2. **American Indian programs.** There is hereby created a section of American
 322.27 Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human
 322.28 Services, to be headed by a special assistant for American Indian programs on ~~alcoholism~~
 322.29 ~~and drug abuse~~ substance misuse and substance use disorder and two assistants to that
 322.30 position. The section shall be staffed with all personnel necessary to fully administer
 322.31 programming for ~~alcohol and drug abuse~~ substance misuse and substance use disorder
 322.32 services for American Indians in the state. The special assistant position shall be filled by
 322.33 a person with considerable practical experience in and understanding of ~~alcohol and other~~
 322.34 ~~drug abuse problems~~ substance misuse and substance use disorder in the American Indian

323.1 community, who shall be responsible to the director of the Alcohol and Drug Abuse Section
 323.2 created in subdivision 1 and shall be in the unclassified service. The special assistant shall
 323.3 meet and consult with the American Indian Advisory Council as described in section
 323.4 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report
 323.5 on the status of ~~alcohol and other drug abuse~~ substance misuse and substance use disorder
 323.6 among American Indians in the state of Minnesota. The special assistant with the approval
 323.7 of the director shall:

323.8 (1) administer funds appropriated for American Indian groups, organizations and
 323.9 reservations within the state for American Indian ~~alcoholism and drug abuse~~ substance
 323.10 misuse and substance use disorder programs;

323.11 (2) establish policies and procedures for such American Indian programs with the
 323.12 assistance of the American Indian Advisory Board; and

323.13 (3) hire and supervise staff to assist in the administration of the American Indian program
 323.14 section within the Alcohol and Drug Abuse Section of the Department of Human Services.

323.15 Subd. 3. **Rules for ~~chemical dependency~~ substance use disorder care.** (a) The
 323.16 commissioner of human services shall establish by rule criteria to be used in determining
 323.17 the appropriate level of chemical dependency care for each recipient of public assistance
 323.18 seeking treatment for ~~alcohol or other drug dependency and abuse problems.~~ substance
 323.19 misuse or substance use disorder. Upon federal approval of a comprehensive assessment
 323.20 as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria
 323.21 in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive
 323.22 assessments under section 254B.05 may determine and approve the appropriate level of
 323.23 substance use disorder treatment for a recipient of public assistance. The process for
 323.24 determining an individual's financial eligibility for the consolidated chemical dependency
 323.25 treatment fund or determining an individual's enrollment in or eligibility for a publicly
 323.26 subsidized health plan is not affected by the individual's choice to access a comprehensive
 323.27 assessment for placement.

323.28 (b) The commissioner shall develop and implement a utilization review process for
 323.29 publicly funded treatment placements to monitor and review the clinical appropriateness
 323.30 and timeliness of all publicly funded placements in treatment.

323.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

324.1 Sec. 41. Minnesota Statutes 2016, section 254A.035, subdivision 1, is amended to read:

324.2 Subdivision 1. **Establishment.** There is created an American Indian Advisory Council
 324.3 to assist the state authority on ~~alcohol and drug abuse~~ substance misuse and substance use
 324.4 disorder in proposal review and formulating policies and procedures relating to ~~chemical~~
 324.5 ~~dependency and the abuse of alcohol and other drugs~~ substance misuse and substance use
 324.6 disorder by American Indians.

324.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

324.8 Sec. 42. Minnesota Statutes 2016, section 254A.04, is amended to read:

324.9 **254A.04 CITIZENS ADVISORY COUNCIL.**

324.10 There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise
 324.11 the Department of Human Services concerning the problems of ~~alcohol and other drug~~
 324.12 ~~dependency and abuse~~ substance misuse and substance use disorder, composed of ten
 324.13 members. Five members shall be individuals whose interests or training are in the field of
 324.14 ~~alcohol dependency~~ alcohol-specific substance use disorder and ~~abuse~~ alcohol misuse; and
 324.15 five members whose interests or training are in the field of ~~dependency~~ substance use
 324.16 disorder and ~~abuse of drugs~~ misuse of substances other than alcohol. The terms, compensation
 324.17 and removal of members shall be as provided in section 15.059. The council expires June
 324.18 30, 2018. The commissioner of human services shall appoint members whose terms end in
 324.19 even-numbered years. The commissioner of health shall appoint members whose terms end
 324.20 in odd-numbered years.

324.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

324.22 Sec. 43. Minnesota Statutes 2016, section 254A.08, is amended to read:

324.23 **254A.08 DETOXIFICATION CENTERS.**

324.24 Subdivision 1. **Detoxification services.** Every county board shall provide detoxification
 324.25 services for ~~drug dependent persons~~ any person incapable of self-management or management
 324.26 of personal affairs or unable to function physically or mentally in an effective manner
 324.27 because of the use of a drug, including alcohol. The board may utilize existing treatment
 324.28 programs and other agencies to meet this responsibility.

324.29 Subd. 2. **Program requirements.** For the purpose of this section, a detoxification
 324.30 program means a social rehabilitation program licensed by the Department of Human
 324.31 Services under Minnesota Rules, parts 9530.6510 to 9530.6590, and established for the
 324.32 purpose of facilitating access into care and treatment by detoxifying and evaluating the

325.1 person and providing entrance into a comprehensive program. Evaluation of the person
 325.2 shall include verification by a professional, after preliminary examination, that the person
 325.3 is intoxicated or has symptoms of ~~chemical dependency~~ substance misuse or substance use
 325.4 disorder and appears to be in imminent danger of harming self or others. A detoxification
 325.5 program shall have available the services of a licensed physician for medical emergencies
 325.6 and routine medical surveillance. A detoxification program licensed by the Department of
 325.7 Human Services to serve both adults and minors at the same site must provide for separate
 325.8 sleeping areas for adults and minors.

325.9 **EFFECTIVE DATE.** This section is effective January 1, 2018.

325.10 Sec. 44. Minnesota Statutes 2016, section 254A.09, is amended to read:

325.11 **254A.09 CONFIDENTIALITY OF RECORDS.**

325.12 The Department of Human Services shall assure confidentiality to individuals who are
 325.13 the subject of research by the state authority or are recipients of ~~alcohol or drug abuse~~
 325.14 substance misuse or substance use disorder information, assessment, or treatment from a
 325.15 licensed or approved program. The commissioner shall withhold from all persons not
 325.16 connected with the conduct of the research the names or other identifying characteristics
 325.17 of a subject of research unless the individual gives written permission that information
 325.18 relative to treatment and recovery may be released. Persons authorized to protect the privacy
 325.19 of subjects of research may not be compelled in any federal, state or local, civil, criminal,
 325.20 administrative or other proceeding to identify or disclose other confidential information
 325.21 about the individuals. Identifying information and other confidential information related to
 325.22 ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment,
 325.23 treatment, or aftercare services may be ordered to be released by the court for the purpose
 325.24 of civil or criminal investigations or proceedings if, after review of the records considered
 325.25 for disclosure, the court determines that the information is relevant to the purpose for which
 325.26 disclosure is requested. The court shall order disclosure of only that information which is
 325.27 determined relevant. In determining whether to compel disclosure, the court shall weigh
 325.28 the public interest and the need for disclosure against the injury to the patient, to the treatment
 325.29 relationship in the program affected and in other programs similarly situated, and the actual
 325.30 or potential harm to the ability of programs to attract and retain patients if disclosure occurs.
 325.31 This section does not exempt any person from the reporting obligations under section
 325.32 626.556, nor limit the use of information reported in any proceeding arising out of the abuse
 325.33 or neglect of a child. Identifying information and other confidential information related to
 325.34 ~~alcohol or drug abuse information~~ substance misuse or substance use disorder, assessment,

326.1 treatment, or aftercare services may be ordered to be released by the court for the purpose
326.2 of civil or criminal investigations or proceedings. No information may be released pursuant
326.3 to this section that would not be released pursuant to section 595.02, subdivision 2.

326.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

326.5 Sec. 45. Minnesota Statutes 2016, section 254A.19, subdivision 3, is amended to read:

326.6 Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b) or (c),
326.7 an assessor conducting a chemical use assessment under Minnesota Rules, parts 9530.6600
326.8 to 9530.6655, may not have any direct or shared financial interest or referral relationship
326.9 resulting in shared financial gain with a treatment provider.

326.10 (b) A county may contract with an assessor having a conflict described in paragraph (a)
326.11 if the county documents that:

326.12 (1) the assessor is employed by a culturally specific service provider or a service provider
326.13 with a program designed to treat individuals of a specific age, sex, or sexual preference;

326.14 (2) the county does not employ a sufficient number of qualified assessors and the only
326.15 qualified assessors available in the county have a direct or shared financial interest or a
326.16 referral relationship resulting in shared financial gain with a treatment provider; or

326.17 (3) the county social service agency has an existing relationship with an assessor or
326.18 service provider and elects to enter into a contract with that assessor to provide both
326.19 assessment and treatment under circumstances specified in the county's contract, provided
326.20 the county retains responsibility for making placement decisions.

326.21 (c) The county may contract with a hospital to conduct chemical assessments if the
326.22 requirements in subdivision 1a are met.

326.23 An assessor under this paragraph may not place clients in treatment. The assessor shall
326.24 gather required information and provide it to the county along with any required
326.25 documentation. The county shall make all placement decisions for clients assessed by
326.26 assessors under this paragraph.

326.27 (d) An eligible vendor under section 254B.05 conducting a comprehensive assessment
326.28 for an individual seeking treatment shall approve the nature, intensity level, and duration
326.29 of treatment service if a need for services is indicated, but the individual assessed can access
326.30 any enrolled provider that is licensed to provide the level of service authorized, including
326.31 the provider or program that completed the assessment. If an individual is enrolled in a

327.1 prepaid health plan, the individual must comply with any provider network requirements
 327.2 or limitations.

327.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

327.4 Sec. 46. Minnesota Statutes 2016, section 254B.01, subdivision 3, is amended to read:

327.5 Subd. 3. ~~Chemical dependency~~ **Substance use disorder treatment services.** "Chemical
 327.6 ~~dependency~~ Substance use disorder treatment services" means a planned program of care
 327.7 for the treatment of ~~chemical dependency~~ substance misuse or ~~chemical abuse~~ substance
 327.8 use disorder to minimize or prevent further ~~chemical abuse~~ substance misuse by the person.
 327.9 Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services that are
 327.10 not part of a program of care licensable as a residential or nonresidential ~~chemical dependency~~
 327.11 substance use disorder treatment program are not ~~chemical dependency~~ substance use
 327.12 disorder services for purposes of this section. For pregnant and postpartum women, ~~chemical~~
 327.13 ~~dependency~~ substance use disorder services include halfway house services, aftercare
 327.14 services, psychological services, and case management.

327.15 **EFFECTIVE DATE.** This section is effective January 1, 2018.

327.16 Sec. 47. Minnesota Statutes 2016, section 254B.01, is amended by adding a subdivision
 327.17 to read:

327.18 Subd. 8. **Recovery community organization.** "Recovery community organization"
 327.19 means an independent organization led and governed by representatives of local communities
 327.20 of recovery. A recovery community organization mobilizes resources within and outside
 327.21 of the recovery community to increase the prevalence and quality of long-term recovery
 327.22 from alcohol and other drug addiction. Recovery community organizations provide
 327.23 peer-based recovery support activities such as training of recovery peers. Recovery
 327.24 community organizations provide mentorship and ongoing support to individuals dealing
 327.25 with a substance use disorder and connect them with the resources that can support each
 327.26 person's recovery. A recovery community organization also promotes a recovery-focused
 327.27 orientation in community education and outreach programming, and organize
 327.28 recovery-focused policy advocacy activities to foster healthy communities and reduce the
 327.29 stigma of substance use disorder.

327.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

328.1 Sec. 48. Minnesota Statutes 2016, section 254B.03, subdivision 2, is amended to read:

328.2 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
328.3 dependency fund is limited to payments for services other than detoxification licensed under
328.4 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
328.5 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
328.6 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
328.7 services other than detoxification provided in another state that would be required to be
328.8 licensed as a chemical dependency program if the program were in the state. Out of state
328.9 vendors must also provide the commissioner with assurances that the program complies
328.10 substantially with state licensing requirements and possesses all licenses and certifications
328.11 required by the host state to provide chemical dependency treatment. ~~Except for chemical~~
328.12 ~~dependency transitional rehabilitation programs,~~ Vendors receiving payments from the
328.13 chemical dependency fund must not require co-payment from a recipient of benefits for
328.14 services provided under this subdivision. The vendor is prohibited from using the client's
328.15 public benefits to offset the cost of services paid under this section. The vendor shall not
328.16 require the client to use public benefits for room or board costs. This includes but is not
328.17 limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits.
328.18 Retention of SNAP benefits is a right of a client receiving services through the consolidated
328.19 chemical dependency treatment fund or through state contracted managed care entities.
328.20 Payment from the chemical dependency fund shall be made for necessary room and board
328.21 costs provided by vendors certified according to section 254B.05, or in a community hospital
328.22 licensed by the commissioner of health according to sections 144.50 to 144.56 to a client
328.23 who is:

328.24 (1) determined to meet the criteria for placement in a residential chemical dependency
328.25 treatment program according to rules adopted under section 254A.03, subdivision 3; and

328.26 (2) concurrently receiving a chemical dependency treatment service in a program licensed
328.27 by the commissioner and reimbursed by the chemical dependency fund.

328.28 (b) A county may, from its own resources, provide chemical dependency services for
328.29 which state payments are not made. A county may elect to use the same invoice procedures
328.30 and obtain the same state payment services as are used for chemical dependency services
328.31 for which state payments are made under this section if county payments are made to the
328.32 state in advance of state payments to vendors. When a county uses the state system for
328.33 payment, the commissioner shall make monthly billings to the county using the most recent
328.34 available information to determine the anticipated services for which payments will be made
328.35 in the coming month. Adjustment of any overestimate or underestimate based on actual

329.1 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
329.2 month.

329.3 (c) The commissioner shall coordinate chemical dependency services and determine
329.4 whether there is a need for any proposed expansion of chemical dependency treatment
329.5 services. The commissioner shall deny vendor certification to any provider that has not
329.6 received prior approval from the commissioner for the creation of new programs or the
329.7 expansion of existing program capacity. The commissioner shall consider the provider's
329.8 capacity to obtain clients from outside the state based on plans, agreements, and previous
329.9 utilization history, when determining the need for new treatment services.

329.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

329.11 Sec. 49. Minnesota Statutes 2016, section 254B.04, subdivision 1, is amended to read:

329.12 Subdivision 1. **Eligibility.** ~~(a)~~ Persons eligible for benefits under Code of Federal
329.13 Regulations, title 25, part 20, and persons eligible for medical assistance benefits under
329.14 sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the
329.15 income standards of section 256B.056, subdivision 4, are entitled to chemical dependency
329.16 fund services. State money appropriated for this paragraph must be placed in a separate
329.17 account established for this purpose.

329.18 Persons with dependent children who are determined to be in need of chemical
329.19 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
329.20 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
329.21 local agency to access needed treatment services. Treatment services must be appropriate
329.22 for the individual or family, which may include long-term care treatment or treatment in a
329.23 facility that allows the dependent children to stay in the treatment facility. The county shall
329.24 pay for out-of-home placement costs, if applicable.

329.25 ~~(b) A person not entitled to services under paragraph (a), but with family income that~~
329.26 ~~is less than 215 percent of the federal poverty guidelines for the applicable family size, shall~~
329.27 ~~be eligible to receive chemical dependency fund services within the limit of funds~~
329.28 ~~appropriated for this group for the fiscal year. If notified by the state agency of limited~~
329.29 ~~funds, a county must give preferential treatment to persons with dependent children who~~
329.30 ~~are in need of chemical dependency treatment pursuant to an assessment under section~~
329.31 ~~626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212.~~
329.32 ~~A county may spend money from its own sources to serve persons under this paragraph.~~
329.33 ~~State money appropriated for this paragraph must be placed in a separate account established~~
329.34 ~~for this purpose.~~

330.1 ~~(e) Persons whose income is between 215 percent and 412 percent of the federal poverty~~
 330.2 ~~guidelines for the applicable family size shall be eligible for chemical dependency services~~
 330.3 ~~on a sliding fee basis, within the limit of funds appropriated for this group for the fiscal~~
 330.4 ~~year. Persons eligible under this paragraph must contribute to the cost of services according~~
 330.5 ~~to the sliding fee scale established under subdivision 3. A county may spend money from~~
 330.6 ~~its own sources to provide services to persons under this paragraph. State money appropriated~~
 330.7 ~~for this paragraph must be placed in a separate account established for this purpose.~~

330.8 **EFFECTIVE DATE.** This section is effective January 1, 2018.

330.9 Sec. 50. Minnesota Statutes 2016, section 254B.04, subdivision 2b, is amended to read:

330.10 Subd. 2b. **Eligibility for placement in opioid treatment programs.** ~~(a) Notwithstanding~~
 330.11 ~~provisions of Minnesota Rules, part 9530.6622, subpart 5, related to a placement authority's~~
 330.12 ~~requirement to authorize services or service coordination in a program that complies with~~
 330.13 ~~Minnesota Rules, part 9530.6500, or Code of Federal Regulations, title 42, part 8, and after~~
 330.14 ~~taking into account an individual's preference for placement in an opioid treatment program,~~
 330.15 ~~a placement authority may, but is not required to, authorize services or service coordination~~
 330.16 ~~or otherwise place an individual in an opioid treatment program. Prior to making a~~
 330.17 ~~determination of placement for an individual, the placing authority must consult with the~~
 330.18 ~~current treatment provider, if any.~~

330.19 ~~(b)~~ Prior to placement of an individual who is determined by the assessor to require
 330.20 treatment for opioid addiction, the assessor must provide educational information concerning
 330.21 treatment options for opioid addiction, including the use of a medication for the use of
 330.22 opioid addiction. The commissioner shall develop educational materials supported by
 330.23 research and updated periodically that must be used by assessors to comply with this
 330.24 requirement.

330.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

330.26 Sec. 51. Minnesota Statutes 2016, section 254B.05, subdivision 1, is amended to read:

330.27 Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are
 330.28 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
 330.29 notwithstanding the provisions of section 245A.03. American Indian programs that provide
 330.30 ~~chemical dependency primary~~ substance use disorder treatment, extended care, transitional
 330.31 residence, or outpatient treatment services, and are licensed by tribal government are eligible
 330.32 vendors.

331.1 (b) On July 1, 2018, or upon federal approval, whichever is later, a licensed professional
 331.2 in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4,
 331.3 is an eligible vendor of a comprehensive assessment and assessment summary provided
 331.4 according to section 245G.05, and treatment services provided according to sections 245G.06
 331.5 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

331.6 (c) On July 1, 2018, or upon federal approval, whichever is later, a county is an eligible
 331.7 vendor for a comprehensive assessment and assessment summary when provided by an
 331.8 individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 4, and
 331.9 completed according to the requirements of section 245G.05. A county is an eligible vendor
 331.10 of care coordination services when provided by an individual who meets the staffing
 331.11 credentials of section 245G.11, subdivisions 1 and 7, and provided according to the
 331.12 requirements of section 245G.07, subdivision 1, clause (7).

331.13 (d) On July 1, 2018, or upon federal approval, whichever is later, a recovery community
 331.14 organization that meets certification requirements identified by the commissioner is an
 331.15 eligible vendor of peer support services.

331.16 (e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
 331.17 9530.6590, are not eligible vendors. Programs that are not licensed as a ~~chemical dependency~~
 331.18 residential or nonresidential substance use disorder treatment or withdrawal management
 331.19 program by the commissioner or by tribal government or do not meet the requirements of
 331.20 subdivisions 1a and 1b are not eligible vendors.

331.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

331.22 Sec. 52. Minnesota Statutes 2016, section 254B.05, subdivision 1a, is amended to read:

331.23 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
 331.24 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

331.25 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
 331.26 while residing in the facility and provide consequences for infractions of those rules;

331.27 (2) is determined to meet applicable health and safety requirements;

331.28 (3) is not a jail or prison;

331.29 (4) is not concurrently receiving funds under chapter 256I for the recipient;

331.30 (5) admits individuals who are 18 years of age or older;

331.31 (6) is registered as a board and lodging or lodging establishment according to section
 331.32 157.17;

- 332.1 (7) has awake staff on site 24 hours per day;
- 332.2 (8) has staff who are at least 18 years of age and meet the requirements of ~~Minnesota~~
 332.3 ~~Rules, part 9530.6450, subpart 1, item A~~ section 245G.11, subdivision 1, paragraph (a);
- 332.4 (9) has emergency behavioral procedures that meet the requirements of ~~Minnesota Rules,~~
 332.5 ~~part 9530.6475~~ section 245G.16;
- 332.6 (10) meets the requirements of ~~Minnesota Rules, part 9530.6435, subparts 3 and 4, items~~
 332.7 ~~A and B~~ section 245G.08, subdivision 5, if administering medications to clients;
- 332.8 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
 332.9 fraternization and the mandatory reporting requirements of section 626.557;
- 332.10 (12) documents coordination with the treatment provider to ensure compliance with
 332.11 section 254B.03, subdivision 2;
- 332.12 (13) protects client funds and ensures freedom from exploitation by meeting the
 332.13 provisions of section 245A.04, subdivision 13;
- 332.14 (14) has a grievance procedure that meets the requirements of ~~Minnesota Rules, part~~
 332.15 ~~9530.6470, subpart 2~~ section 245G.15, subdivision 2; and
- 332.16 (15) has sleeping and bathroom facilities for men and women separated by a door that
 332.17 is locked, has an alarm, or is supervised by awake staff.
- 332.18 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
 332.19 paragraph (a), clauses (5) to (15).

332.20 **EFFECTIVE DATE.** This section is effective January 1, 2018.

332.21 Sec. 53. Minnesota Statutes 2016, section 254B.05, subdivision 5, is amended to read:

332.22 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for ~~chemical~~
 332.23 ~~dependency~~ substance use disorder services and service enhancements funded under this
 332.24 chapter.

332.25 (b) Eligible ~~chemical dependency~~ substance use disorder treatment services include:

332.26 (1) outpatient treatment services that are licensed according to ~~Minnesota Rules, parts~~
 332.27 ~~9530.6405 to 9530.6480~~ sections 245G.01 to 245G.17, or applicable tribal license;

332.28 (2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive
 332.29 assessments provided according to sections 245.4863, paragraph (a), and 245G.05, and
 332.30 Minnesota Rules, part 9530.6422;

333.1 (3) on July 1, 2018, or upon federal approval, whichever is later, care coordination
 333.2 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

333.3 (4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
 333.4 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

333.5 (5) on July 1, 2018, or upon federal approval, whichever is later, withdrawal management
 333.6 services provided according to chapter 245F;

333.7 ~~(2)~~ (6) medication-assisted therapy services that are licensed according to ~~Minnesota~~
 333.8 ~~Rules, parts 9530.6405 to 9530.6480 and 9530.6500~~ section 245G.07, subdivision 1, or
 333.9 applicable tribal license;

333.10 ~~(3)~~ (7) medication-assisted therapy plus enhanced treatment services that meet the
 333.11 requirements of clause ~~(2)~~ (6) and provide nine hours of clinical services each week;

333.12 ~~(4)~~ (8) high, medium, and low intensity residential treatment services that are licensed
 333.13 according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections
 333.14 245G.01 to 245G.17 and 245G.22 or applicable tribal license which provide, respectively,
 333.15 30, 15, and five hours of clinical services each week;

333.16 ~~(5)~~ (9) hospital-based treatment services that are licensed according to ~~Minnesota Rules,~~
 333.17 ~~parts 9530.6405 to 9530.6480,~~ sections 245G.01 to 245G.17 or applicable tribal license and
 333.18 licensed as a hospital under sections 144.50 to 144.56;

333.19 ~~(6)~~ (10) adolescent treatment programs that are licensed as outpatient treatment programs
 333.20 according to ~~Minnesota Rules, parts 9530.6405 to 9530.6485,~~ sections 245G.01 to 245G.18
 333.21 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to
 333.22 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

333.23 ~~(7)~~ (11) high-intensity residential treatment services that are licensed according to
 333.24 ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505,~~ sections 245G.01 to 245G.17
 333.25 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each
 333.26 week provided by a state-operated vendor or to clients who have been civilly committed to
 333.27 the commissioner, present the most complex and difficult care needs, and are a potential
 333.28 threat to the community; and

333.29 ~~(8)~~ (12) room and board facilities that meet the requirements of subdivision 1a.

333.30 (c) The commissioner shall establish higher rates for programs that meet the requirements
 333.31 of paragraph (b) and one of the following additional requirements:

333.32 (1) programs that serve parents with their children if the program:

- 334.1 (i) provides on-site child care during the hours of treatment activity that:
- 334.2 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
- 334.3 9503; or
- 334.4 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
- 334.5 (a), clause (6), and meets the requirements under ~~Minnesota Rules, part 9530.6490, subpart~~
- 334.6 4 section 245G.19, subdivision 4; or
- 334.7 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
- 334.8 licensed under chapter 245A as:
- 334.9 (A) a child care center under Minnesota Rules, chapter 9503; or
- 334.10 (B) a family child care home under Minnesota Rules, chapter 9502;
- 334.11 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
- 334.12 programs or subprograms serving special populations, if the program or subprogram meets
- 334.13 the following requirements:
- 334.14 (i) is designed to address the unique needs of individuals who share a common language,
- 334.15 racial, ethnic, or social background;
- 334.16 (ii) is governed with significant input from individuals of that specific background; and
- 334.17 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
- 334.18 whom are of that specific background, except when the common social background of the
- 334.19 individuals served is a traumatic brain injury or cognitive disability and the program employs
- 334.20 treatment staff who have the necessary professional training, as approved by the
- 334.21 commissioner, to serve clients with the specific disabilities that the program is designed to
- 334.22 serve;
- 334.23 (3) programs that offer medical services delivered by appropriately credentialed health
- 334.24 care staff in an amount equal to two hours per client per week if the medical needs of the
- 334.25 client and the nature and provision of any medical services provided are documented in the
- 334.26 client file; and
- 334.27 (4) programs that offer services to individuals with co-occurring mental health and
- 334.28 chemical dependency problems if:
- 334.29 (i) the program meets the co-occurring requirements in ~~Minnesota Rules, part 9530.6495~~
- 334.30 section 245G.20;
- 334.31 (ii) 25 percent of the counseling staff are licensed mental health professionals, as defined
- 334.32 in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates

335.1 under the supervision of a licensed alcohol and drug counselor supervisor and licensed
335.2 mental health professional, except that no more than 50 percent of the mental health staff
335.3 may be students or licensing candidates with time documented to be directly related to
335.4 provisions of co-occurring services;

335.5 (iii) clients scoring positive on a standardized mental health screen receive a mental
335.6 health diagnostic assessment within ten days of admission;

335.7 (iv) the program has standards for multidisciplinary case review that include a monthly
335.8 review for each client that, at a minimum, includes a licensed mental health professional
335.9 and licensed alcohol and drug counselor, and their involvement in the review is documented;

335.10 (v) family education is offered that addresses mental health and substance abuse disorders
335.11 and the interaction between the two; and

335.12 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
335.13 training annually.

335.14 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
335.15 that provides arrangements for off-site child care must maintain current documentation at
335.16 the chemical dependency facility of the child care provider's current licensure to provide
335.17 child care services. Programs that provide child care according to paragraph (c), clause (1),
335.18 must be deemed in compliance with the licensing requirements in ~~Minnesota Rules, part~~
335.19 ~~9530.6490~~ section 245G.19.

335.20 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
335.21 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
335.22 in paragraph (c), clause (4), items (i) to (iv).

335.23 (f) Subject to federal approval, chemical dependency services that are otherwise covered
335.24 as direct face-to-face services may be provided via two-way interactive video. The use of
335.25 two-way interactive video must be medically appropriate to the condition and needs of the
335.26 person being served. Reimbursement shall be at the same rates and under the same conditions
335.27 that would otherwise apply to direct face-to-face services. The interactive video equipment
335.28 and connection must comply with Medicare standards in effect at the time the service is
335.29 provided.

335.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

336.1 Sec. 54. Minnesota Statutes 2016, section 254B.051, is amended to read:

336.2 **254B.051 SUBSTANCE ~~ABUSE~~ USE DISORDER TREATMENT**
 336.3 **EFFECTIVENESS.**

336.4 In addition to the substance ~~abuse~~ use disorder treatment program performance outcome
 336.5 measures that the commissioner of human services collects annually from treatment providers,
 336.6 the commissioner shall request additional data from programs that receive appropriations
 336.7 from the consolidated chemical dependency treatment fund. This data shall include number
 336.8 of client readmissions six months after release from inpatient treatment, and the cost of
 336.9 treatment per person for each program receiving consolidated chemical dependency treatment
 336.10 funds. The commissioner may post this data on the department Web site.

336.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

336.12 Sec. 55. Minnesota Statutes 2016, section 254B.07, is amended to read:

336.13 **254B.07 THIRD-PARTY LIABILITY.**

336.14 The state agency provision and payment of, or liability for, ~~chemical dependency~~
 336.15 substance use disorder medical care is the same as in section 256B.042.

336.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

336.17 Sec. 56. Minnesota Statutes 2016, section 254B.08, is amended to read:

336.18 **254B.08 FEDERAL WAIVERS.**

336.19 The commissioner shall apply for any federal waivers necessary to secure, to the extent
 336.20 allowed by law, federal financial participation for the provision of services to persons who
 336.21 need ~~chemical dependency~~ substance use disorder services. The commissioner may seek
 336.22 amendments to the waivers or apply for additional waivers to contain costs. The
 336.23 commissioner shall ensure that payment for the cost of providing ~~chemical dependency~~
 336.24 substance use disorder services under the federal waiver plan does not exceed the cost of
 336.25 ~~chemical dependency~~ substance use disorder services that would have been provided without
 336.26 the waived services.

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

336.28 Sec. 57. Minnesota Statutes 2016, section 254B.09, is amended to read:

336.29 **254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL**
 336.30 **DEPENDENCY FUND.**

337.1 Subdivision 1. **Vendor payments.** The commissioner shall pay eligible vendors for
337.2 ~~chemical dependency~~ substance use disorder services to American Indians on the same
337.3 basis as other payments, except that no local match is required when an invoice is submitted
337.4 by the governing authority of a federally recognized American Indian tribal body or a county
337.5 if the tribal governing body has not entered into an agreement under subdivision 2 on behalf
337.6 of a current resident of the reservation under this section.

337.7 Subd. 2. **American Indian agreements.** The commissioner may enter into agreements
337.8 with federally recognized tribal units to pay for ~~chemical dependency~~ substance use disorder
337.9 treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements
337.10 must clarify how the governing body of the tribal unit fulfills local agency responsibilities
337.11 regarding:

337.12 (1) the form and manner of invoicing; and

337.13 (2) provide that only invoices for eligible vendors according to section 254B.05 will be
337.14 included in invoices sent to the commissioner for payment, to the extent that money allocated
337.15 under subdivisions 4 and 5 is used.

337.16 Subd. 6. **American Indian tribal placements.** After entering into an agreement under
337.17 subdivision 2, the governing authority of each reservation may submit invoices to the state
337.18 for the cost of providing ~~chemical dependency~~ substance use disorder services to residents
337.19 of the reservation according to the placement rules governing county placements, except
337.20 that local match requirements are waived. The governing body may designate an agency to
337.21 act on its behalf to provide placement services and manage invoices by written notice to
337.22 the commissioner and evidence of agreement by the agency designated.

337.23 Subd. 8. **Payments to improve services to American Indians.** The commissioner may
337.24 set rates for ~~chemical dependency~~ substance use disorder services to American Indians
337.25 according to the American Indian Health Improvement Act, Public Law 94-437, for eligible
337.26 vendors. These rates shall supersede rates set in county purchase of service agreements
337.27 when payments are made on behalf of clients eligible according to Public Law 94-437.

337.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

337.29 Sec. 58. Minnesota Statutes 2016, section 254B.12, subdivision 2, is amended to read:

337.30 Subd. 2. **Payment methodology for highly specialized vendors.** Notwithstanding
337.31 subdivision 1, the commissioner shall seek federal authority to develop separate payment
337.32 methodologies for ~~chemical dependency~~ substance use disorder treatment services provided
337.33 under the consolidated chemical dependency treatment fund: (1) by a state-operated vendor;

338.1 or (2) for persons who have been civilly committed to the commissioner, present the most
338.2 complex and difficult care needs, and are a potential threat to the community. A payment
338.3 methodology under this subdivision is effective for services provided on or after October
338.4 1, 2015, or on or after the receipt of federal approval, whichever is later.

338.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

338.6 Sec. 59. Minnesota Statutes 2016, section 254B.13, subdivision 2a, is amended to read:

338.7 Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation
338.8 in a navigator pilot program, an individual must:

338.9 (1) be a resident of a county with an approved navigator program;

338.10 (2) be eligible for consolidated chemical dependency treatment fund services;

338.11 (3) be a voluntary participant in the navigator program;

338.12 (4) satisfy one of the following items:

338.13 (i) have at least one severity rating of three or above in dimension four, five, or six in a
338.14 comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~ section 245G.05,
338.15 paragraph (c), clauses (4) to (6); or

338.16 (ii) have at least one severity rating of two or above in dimension four, five, or six in a
338.17 comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~, section 245G.05,
338.18 paragraph (c), clauses (4) to (6), and be currently participating in a Rule 31 treatment program
338.19 under ~~Minnesota Rules, parts 9530.6405 to 9530.6505~~, chapter 245G or be within 60 days
338.20 following discharge after participation in a Rule 31 treatment program; and

338.21 (5) have had at least two treatment episodes in the past two years, not limited to episodes
338.22 reimbursed by the consolidated chemical dependency treatment funds. An admission to an
338.23 emergency room, a detoxification program, or a hospital may be substituted for one treatment
338.24 episode if it resulted from the individual's substance use disorder.

338.25 (b) New eligibility criteria may be added as mutually agreed upon by the commissioner
338.26 and participating navigator programs.

338.27 **EFFECTIVE DATE.** This section is effective January 1, 2018.

339.1 Sec. 60. Minnesota Statutes 2016, section 256B.0625, subdivision 45a, is amended to
339.2 read:

339.3 Subd. 45a. **Psychiatric residential treatment facility services for persons under 21**
339.4 **years of age.** (a) Medical assistance covers psychiatric residential treatment facility services,
339.5 according to section 256B.0941, for persons ~~under~~ younger than 21 years of age. Individuals
339.6 who reach age 21 at the time they are receiving services are eligible to continue receiving
339.7 services until they no longer require services or until they reach age 22, whichever occurs
339.8 first.

339.9 (b) For purposes of this subdivision, "psychiatric residential treatment facility" means
339.10 a facility other than a hospital that provides psychiatric services, as described in Code of
339.11 Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in
339.12 an inpatient setting.

339.13 ~~(c) The commissioner shall develop admissions and discharge procedures and establish~~
339.14 ~~rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.~~

339.15 ~~(d)~~ The commissioner shall enroll up to 150 certified psychiatric residential treatment
339.16 facility services beds at up to six sites. The commissioner shall select psychiatric residential
339.17 treatment facility services providers through a request for proposals process. Providers of
339.18 state-operated services may respond to the request for proposals.

339.19 Sec. 61. **[256B.0941] PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY**
339.20 **FOR PERSONS UNDER 21 YEARS OF AGE.**

339.21 Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment
339.22 services in a psychiatric residential treatment facility must meet all of the following criteria:

339.23 (1) before admission, services are determined to be medically necessary by the state's
339.24 medical review agent according to Code of Federal Regulations, title 42, section 441.152;

339.25 (2) is younger than 21 years of age at the time of admission. Services may continue until
339.26 the individual meets criteria for discharge or reaches 22 years of age, whichever occurs
339.27 first;

339.28 (3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic
339.29 and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression,
339.30 or a finding that the individual is a risk to self or others;

339.31 (4) has functional impairment and a history of difficulty in functioning safely and
339.32 successfully in the community, school, home, or job; an inability to adequately care for

340.1 one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill
340.2 the individual's needs;

340.3 (5) requires psychiatric residential treatment under the direction of a physician to improve
340.4 the individual's condition or prevent further regression so that services will no longer be
340.5 needed;

340.6 (6) utilized and exhausted other community-based mental health services, or clinical
340.7 evidence indicates that such services cannot provide the level of care needed; and

340.8 (7) was referred for treatment in a psychiatric residential treatment facility by a qualified
340.9 mental health professional licensed as defined in section 245.4871, subdivision 27, clauses
340.10 (1) to (6).

340.11 (b) A mental health professional making a referral shall submit documentation to the
340.12 state's medical review agent containing all information necessary to determine medical
340.13 necessity, including a standard diagnostic assessment completed within 180 days of the
340.14 individual's admission. Documentation shall include evidence of family participation in the
340.15 individual's treatment planning and signed consent for services.

340.16 Subd. 2. Services. Psychiatric residential treatment facility service providers must offer
340.17 and have the capacity to provide the following services:

340.18 (1) development of the individual plan of care, review of the individual plan of care
340.19 every 30 days, and discharge planning by required members of the treatment team according
340.20 to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

340.21 (2) any services provided by a psychiatrist or physician for development of an individual
340.22 plan of care, conducting a review of the individual plan of care every 30 days, and discharge
340.23 planning by required members of the treatment team according to Code of Federal
340.24 Regulations, title 42, sections 441.155 to 441.156;

340.25 (3) active treatment seven days per week that may include individual, family, or group
340.26 therapy as determined by the individual care plan;

340.27 (4) individual therapy, provided a minimum of twice per week;

340.28 (5) family engagement activities, provided a minimum of once per week;

340.29 (6) consultation with other professionals, including case managers, primary care
340.30 professionals, community-based mental health providers, school staff, or other support
340.31 planners;

341.1 (7) coordination of educational services between local and resident school districts and
341.2 the facility;

341.3 (8) 24-hour nursing; and

341.4 (9) direct care and supervision, supportive services for daily living and safety, and
341.5 positive behavior management.

341.6 Subd. 3. **Per diem rate.** (a) The commissioner shall establish a statewide per diem rate
341.7 for psychiatric residential treatment facility services for individuals 21 years of age or
341.8 younger. The rate for a provider must not exceed the rate charged by that provider for the
341.9 same service to other payers. Payment must not be made to more than one entity for each
341.10 individual for services provided under this section on a given day. The commissioner shall
341.11 set rates prospectively for the annual rate period. The commissioner shall require providers
341.12 to submit annual cost reports on a uniform cost reporting form and shall use submitted cost
341.13 reports to inform the rate-setting process. The cost reporting shall be done according to
341.14 federal requirements for Medicare cost reports.

341.15 (b) The following are included in the rate:

341.16 (1) costs necessary for licensure and accreditation, meeting all staffing standards for
341.17 participation, meeting all service standards for participation, meeting all requirements for
341.18 active treatment, maintaining medical records, conducting utilization review, meeting
341.19 inspection of care, and discharge planning. The direct services costs must be determined
341.20 using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff
341.21 and service-related transportation; and

341.22 (2) payment for room and board provided by facilities meeting all accreditation and
341.23 licensing requirements for participation.

341.24 (c) A facility may submit a claim for payment outside of the per diem for professional
341.25 services arranged by and provided at the facility by an appropriately licensed professional
341.26 who is enrolled as a provider with Minnesota health care programs. Arranged services must
341.27 be billed by the facility on a separate claim, and the facility shall be responsible for payment
341.28 to the provider. These services must be included in the individual plan of care and are subject
341.29 to prior authorization by the state's medical review agent.

341.30 (d) Medicaid shall reimburse for concurrent services as approved by the commissioner
341.31 to support continuity of care and successful discharge from the facility. "Concurrent services"
341.32 means services provided by another entity or provider while the individual is admitted to a
341.33 psychiatric residential treatment facility. Payment for concurrent services may be limited

342.1 and these services are subject to prior authorization by the state's medical review agent.

342.2 Concurrent services may include targeted case management, assertive community treatment,
342.3 clinical care consultation, team consultation, and treatment planning.

342.4 (e) Payment rates under this subdivision shall not include the costs of providing the
342.5 following services:

342.6 (1) educational services;

342.7 (2) acute medical care or specialty services for other medical conditions;

342.8 (3) dental services; and

342.9 (4) pharmacy drug costs.

342.10 (f) For purposes of this section, "actual cost" means costs that are allowable, allocable,
342.11 reasonable, and consistent with federal reimbursement requirements in Code of Federal
342.12 Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of
342.13 Management and Budget Circular Number A-122, relating to nonprofit entities.

342.14 Subd. 4. **Leave days.** (a) Medical assistance covers therapeutic and hospital leave days,
342.15 provided the recipient was not discharged from the psychiatric residential treatment facility
342.16 and is expected to return to the psychiatric residential treatment facility. A reserved bed
342.17 must be held for a recipient on hospital leave or therapeutic leave.

342.18 (b) A therapeutic leave day to home shall be used to prepare for discharge and
342.19 reintegration and shall be included in the individual plan of care. The state shall reimburse
342.20 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic
342.21 leave. A therapeutic leave visit may not exceed three days without prior authorization.

342.22 (c) A hospital leave day shall be a day for which a recipient has been admitted to a
342.23 hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric
342.24 residential treatment facility. The state shall reimburse 50 percent of the per diem rate for
342.25 a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

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

342.27 Sec. 62. Minnesota Statutes 2016, section 256B.0943, subdivision 13, is amended to read:

342.28 Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15
342.29 hours of children's therapeutic services and supports provided within a six-month period to
342.30 a child with severe emotional disturbance who is residing in a hospital; ~~a group home as~~
342.31 ~~defined in Minnesota Rules, parts 2960.0130 to 2960.0220;~~ a residential treatment facility
342.32 licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential

343.1 treatment facility under section 256B.0625, subdivision 45a; a regional treatment center;
343.2 or other institutional group setting or who is participating in a program of partial
343.3 hospitalization are eligible for medical assistance payment if part of the discharge plan.

343.4 Sec. 63. Minnesota Statutes 2016, section 256B.0945, subdivision 2, is amended to read:

343.5 Subd. 2. **Covered services.** All services must be included in a child's individualized
343.6 treatment or multiagency plan of care as defined in chapter 245.

343.7 For facilities that are not institutions for mental diseases according to federal statute and
343.8 regulation, medical assistance covers mental health-related services that are required to be
343.9 provided by a residential facility under section 245.4882 and administrative rules promulgated
343.10 thereunder, except for room and board. For residential facilities determined by the federal
343.11 Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical
343.12 assistance covers medically necessary mental health services provided by the facility
343.13 according to section 256B.055, subdivision 13, except for room and board.

343.14 Sec. 64. Minnesota Statutes 2016, section 256B.0945, subdivision 4, is amended to read:

343.15 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments
343.16 to counties for residential services provided under this section by a residential facility shall:

343.17 (1) for services provided by a residential facility that is not an institution for mental
343.18 diseases, only be made of federal earnings for services provided ~~under this section~~, and the
343.19 nonfederal share of costs for services provided under this section shall be paid by the county
343.20 from sources other than federal funds or funds used to match other federal funds. Payment
343.21 to counties for services provided according to this section shall be a proportion of the per
343.22 day contract rate that relates to rehabilitative mental health services and shall not include
343.23 payment for costs or services that are billed to the IV-E program as room and board; and

343.24 (2) for services provided by a residential facility that is determined to be an institution
343.25 for mental diseases, be equivalent to the federal share of the payment that would have been
343.26 made if the residential facility were not an institution for mental diseases. The portion of
343.27 the payment representing what would be the nonfederal shares shall be paid by the county.
343.28 Payment to counties for services provided according to this section shall be a proportion of
343.29 the per day contract rate that relates to rehabilitative mental health services and shall not
343.30 include payment for costs or services that are billed to the IV-E program as room and board.

343.31 (b) Per diem rates paid to providers under this section by prepaid plans shall be the
343.32 proportion of the per-day contract rate that relates to rehabilitative mental health services

344.1 and shall not include payment for group foster care costs or services that are billed to the
344.2 county of financial responsibility. Services provided in facilities located in bordering states
344.3 are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a)
344.4 and are not covered under prepaid health plans.

344.5 (c) Payment for mental health rehabilitative services provided under this section by or
344.6 under contract with an American Indian tribe or tribal organization or by agencies operated
344.7 by or under contract with an American Indian tribe or tribal organization must be made
344.8 according to section 256B.0625, subdivision 34, or other relevant federally approved
344.9 rate-setting methodology.

344.10 (d) The commissioner shall set aside a portion not to exceed five percent of the federal
344.11 funds earned for county expenditures under this section to cover the state costs of
344.12 administering this section. Any unexpended funds from the set-aside shall be distributed to
344.13 the counties in proportion to their earnings under this section.

344.14 Sec. 65. **CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

344.15 The commissioner of human services shall conduct a comprehensive analysis of
344.16 Minnesota's continuum of intensive mental health services and shall develop
344.17 recommendations for a sustainable and community-driven continuum of care for children
344.18 with serious mental health needs, including children currently being served in residential
344.19 treatment. The commissioner's analysis shall include, but not be limited to:

344.20 (1) data related to access, utilization, efficacy, and outcomes for Minnesota's current
344.21 system of residential mental health treatment for a child with a severe emotional disturbance;

344.22 (2) potential expansion of the state's psychiatric residential treatment facility (PRTF)
344.23 capacity, including increasing the number of PRTF beds and conversion of existing children's
344.24 mental health residential treatment programs into PRTFs;

344.25 (3) the capacity need for PRTF and other group settings within the state if adequate
344.26 community-based alternatives are accessible, equitable, and effective statewide;

344.27 (4) recommendations for expanding alternative community-based service models to
344.28 meet the needs of a child with a serious mental health disorder who would otherwise require
344.29 residential treatment and potential service models that could be utilized, including data
344.30 related to access, utilization, efficacy, and outcomes;

344.31 (5) models of care used in other states; and

345.1 (6) analysis and specific recommendations for the design and implementation of new
345.2 service models, including analysis to inform rate setting as necessary.

345.3 The analysis shall be supported and informed by extensive stakeholder engagement.
345.4 Stakeholders include individuals who receive services, family members of individuals who
345.5 receive services, providers, counties, health plans, advocates, and others. Stakeholder
345.6 engagement shall include interviews with key stakeholders, intentional outreach to individuals
345.7 who receive services and the individual's family members, and regional listening sessions.

345.8 The commissioner shall provide a report with specific recommendations and timelines
345.9 for implementation to the legislative committees with jurisdiction over children's mental
345.10 health policy and finance by November 15, 2018.

345.11 Sec. 66. **RESIDENTIAL TREATMENT AND PAYMENT RATE REFORM.**

345.12 The commissioner shall contract with an outside expert to identify recommendations
345.13 for the development of a substance use disorder residential treatment program model and
345.14 payment structure that is not subject to the federal institutions for mental diseases exclusion
345.15 and that is financially sustainable for providers, while incentivizing best practices and
345.16 improved treatment outcomes. The analysis and report must include recommendations and
345.17 a timeline for supporting providers to transition to the new models of care delivery. No later
345.18 than December 15, 2018, a report with recommendations must be delivered to members of
345.19 the legislative committees in the house of representatives and senate with jurisdiction over
345.20 health and human services policy and finance.

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

345.22 Sec. 67. **REVISOR'S INSTRUCTION.**

345.23 In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with
345.24 the with the Department of Human Services, shall make necessary cross-reference changes
345.25 that are needed as a result of the enactment of sections 6 to 27 and 65. The revisor shall
345.26 make any necessary technical and grammatical changes to preserve the meaning of the text.

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

345.28 Sec. 68. **REPEALER.**

345.29 (a) Minnesota Statutes 2016, sections 245A.1915; 245A.192; and 254A.02, subdivision
345.30 4, are repealed.

346.1 (b) Minnesota Rules, parts 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11,
 346.2 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, and 21; 9530.6410; 9530.6415;
 346.3 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445;
 346.4 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480;
 346.5 9530.6485; 9530.6490; 9530.6495; 9530.6500; and 9530.6505, are repealed.

346.6 **EFFECTIVE DATE.** This section is effective January 1, 2018.

346.7 **ARTICLE 9**

346.8 **OPERATIONS**

346.9 Section 1. Minnesota Statutes 2016, section 13.46, subdivision 4, is amended to read:

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

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

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

346.17 (3) "personal and personal financial data" are Social Security numbers, identity of and
 346.18 letters of reference, insurance information, reports from the Bureau of Criminal
 346.19 Apprehension, health examination reports, and social/home studies.

346.20 (b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license
 346.21 holders, and former licensees are public: name, address, telephone number of licensees,
 346.22 date of receipt of a completed application, dates of licensure, licensed capacity, type of
 346.23 client preferred, variances granted, record of training and education in child care and child
 346.24 development, type of dwelling, name and relationship of other family members, previous
 346.25 license history, class of license, the existence and status of complaints, and the number of
 346.26 serious injuries to or deaths of individuals in the licensed program as reported to the
 346.27 commissioner of human services, the local social services agency, or any other county
 346.28 welfare agency. For purposes of this clause, a serious injury is one that ~~is treated~~ requires
 346.29 treatment by a physician.

346.30 (ii) when a correction order, an order to forfeit a fine, an order of license suspension, an
 346.31 order of temporary immediate suspension, an order of license revocation, an order of license
 346.32 denial, or an order of conditional license has been issued, or a complaint is resolved, the

347.1 following data on current and former licensees and applicants are public: the general nature
347.2 of the complaint or allegations leading to the temporary immediate suspension; the substance
347.3 and investigative findings of the licensing or maltreatment complaint, licensing violation,
347.4 or substantiated maltreatment; the existence of settlement negotiations; the record of informal
347.5 resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law;
347.6 specifications of the final correction order, fine, suspension, temporary immediate suspension,
347.7 revocation, denial, or conditional license contained in the record of licensing action; whether
347.8 a fine has been paid; and the status of any appeal of these actions.

347.9 (iii) When a license denial under section 245A.05 or a sanction under section 245A.07
347.10 is based on a determination that a license holder, applicant, or controlling individual is
347.11 responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant,
347.12 license holder, or controlling individual as the individual responsible for maltreatment is
347.13 public data at the time of the issuance of the license denial or sanction.

347.14 (iv) When a license denial under section 245A.05 or a sanction under section 245A.07
347.15 is based on a determination that a license holder, applicant, or controlling individual is
347.16 disqualified under chapter 245C, the identity of the license holder, applicant, or controlling
347.17 individual as the disqualified individual and the reason for the disqualification are public
347.18 data at the time of the issuance of the licensing sanction or denial. If the applicant, license
347.19 holder, or controlling individual requests reconsideration of the disqualification and the
347.20 disqualification is affirmed, the reason for the disqualification and the reason to not set aside
347.21 the disqualification are public data.

347.22 (2) For applicants who withdraw their application prior to licensure or denial of a license,
347.23 the following data are public: the name of the applicant, the city and county in which the
347.24 applicant was seeking licensure, the dates of the commissioner's receipt of the initial
347.25 application and completed application, the type of license sought, and the date of withdrawal
347.26 of the application.

347.27 (3) for applicants who are denied a license, the following data are public: the name and
347.28 address of the applicant, the city and county in which the applicant was seeking licensure,
347.29 the dates of the commissioner's receipt of the initial application and completed application,
347.30 the type of license sought, the date of denial of the application, the nature of the basis for
347.31 the denial, the existence of settlement negotiations, the record of informal resolution of a
347.32 denial, orders of hearings, findings of fact, conclusions of law, specifications of the final
347.33 order of denial, and the status of any appeal of the denial.

348.1 (4) When maltreatment is substantiated under section 626.556 or 626.557 and the victim
348.2 and the substantiated perpetrator are affiliated with a program licensed under chapter 245A,
348.3 the commissioner of human services, local social services agency, or county welfare agency
348.4 may inform the license holder where the maltreatment occurred of the identity of the
348.5 substantiated perpetrator and the victim.

348.6 (5) Notwithstanding clause (1), for child foster care, only the name of the license holder
348.7 and the status of the license are public if the county attorney has requested that data otherwise
348.8 classified as public data under clause (1) be considered private data based on the best interests
348.9 of a child in placement in a licensed program.

348.10 (c) The following are private data on individuals under section 13.02, subdivision 12,
348.11 or nonpublic data under section 13.02, subdivision 9: personal and personal financial data
348.12 on family day care program and family foster care program applicants and licensees and
348.13 their family members who provide services under the license.

348.14 (d) The following are private data on individuals: the identity of persons who have made
348.15 reports concerning licensees or applicants that appear in inactive investigative data, and the
348.16 records of clients or employees of the licensee or applicant for licensure whose records are
348.17 received by the licensing agency for purposes of review or in anticipation of a contested
348.18 matter. The names of reporters of complaints or alleged violations of licensing standards
348.19 under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment
348.20 under sections 626.556 and 626.557, are confidential data and may be disclosed only as
348.21 provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

348.22 (e) Data classified as private, confidential, nonpublic, or protected nonpublic under this
348.23 subdivision become public data if submitted to a court or administrative law judge as part
348.24 of a disciplinary proceeding in which there is a public hearing concerning a license which
348.25 has been suspended, immediately suspended, revoked, or denied.

348.26 (f) Data generated in the course of licensing investigations that relate to an alleged
348.27 violation of law are investigative data under subdivision 3.

348.28 (g) Data that are not public data collected, maintained, used, or disseminated under this
348.29 subdivision that relate to or are derived from a report as defined in section 626.556,
348.30 subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of
348.31 sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

348.32 (h) Upon request, not public data collected, maintained, used, or disseminated under
348.33 this subdivision that relate to or are derived from a report of substantiated maltreatment as
348.34 defined in section 626.556 or 626.557 may be exchanged with the Department of Health

349.1 for purposes of completing background studies pursuant to section 144.057 and with the
349.2 Department of Corrections for purposes of completing background studies pursuant to
349.3 section 241.021.

349.4 (i) Data on individuals collected according to licensing activities under chapters 245A
349.5 and 245C, data on individuals collected by the commissioner of human services according
349.6 to investigations under chapters 245A, 245B, 245C, and 245D, and sections 626.556 and
349.7 626.557 may be shared with the Department of Human Rights, the Department of Health,
349.8 the Department of Corrections, the ombudsman for mental health and developmental
349.9 disabilities, and the individual's professional regulatory board when there is reason to believe
349.10 that laws or standards under the jurisdiction of those agencies may have been violated or
349.11 the information may otherwise be relevant to the board's regulatory jurisdiction. Background
349.12 study data on an individual who is the subject of a background study under chapter 245C
349.13 for a licensed service for which the commissioner of human services is the license holder
349.14 may be shared with the commissioner and the commissioner's delegate by the licensing
349.15 division. Unless otherwise specified in this chapter, the identity of a reporter of alleged
349.16 maltreatment or licensing violations may not be disclosed.

349.17 (j) In addition to the notice of determinations required under section 626.556, subdivision
349.18 10f, if the commissioner or the local social services agency has determined that an individual
349.19 is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined
349.20 in section 626.556, subdivision 2, and the commissioner or local social services agency
349.21 knows that the individual is a person responsible for a child's care in another facility, the
349.22 commissioner or local social services agency shall notify the head of that facility of this
349.23 determination. The notification must include an explanation of the individual's available
349.24 appeal rights and the status of any appeal. If a notice is given under this paragraph, the
349.25 government entity making the notification shall provide a copy of the notice to the individual
349.26 who is the subject of the notice.

349.27 (k) All not public data collected, maintained, used, or disseminated under this subdivision
349.28 and subdivision 3 may be exchanged between the Department of Human Services, Licensing
349.29 Division, and the Department of Corrections for purposes of regulating services for which
349.30 the Department of Human Services and the Department of Corrections have regulatory
349.31 authority.

349.32 Sec. 2. Minnesota Statutes 2016, section 245A.02, subdivision 2b, is amended to read:

349.33 Subd. 2b. **Annual or annually.** With the exception of subdivision 2c, "annual" or
349.34 "annually" means prior to or within the same month of the subsequent calendar year.

350.1 Sec. 3. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to
350.2 read:

350.3 Subd. 2c. **Annual or annually; family child care training requirements.** For the
350.4 purposes of section 245A.50, subdivisions 1 to 9, "annual" or "annually" means the 12-month
350.5 period beginning on the license effective date or the annual anniversary of the effective date
350.6 and ending on the day prior to the annual anniversary of the license effective date.

350.7 Sec. 4. **[245A.055] NOTIFICATION TO PROVIDER.**

350.8 (a) When the county agency responsible for family child care and group family child
350.9 care licensing conducts an annual or biennial licensing inspection, the agency must provide,
350.10 before departure from the residence or facility, a written or electronic notification to the
350.11 licensee of potential licensing violations noted during the inspection and the condition that
350.12 constitutes the violation.

350.13 (b) Providing this notification to the licensee does not relieve the county agency from
350.14 notifying the license holder and the commissioner of the violation as required by statute or
350.15 rule.

350.16 Sec. 5. Minnesota Statutes 2016, section 245A.06, subdivision 2, is amended to read:

350.17 Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder
350.18 believes that the contents of the commissioner's correction order are in error, the applicant
350.19 or license holder may ask the Department of Human Services to reconsider the parts of the
350.20 correction order that are alleged to be in error. The request for reconsideration must be made
350.21 in writing and must be postmarked and sent to the commissioner within 20 calendar days
350.22 after receipt of the correction order by the applicant or license holder, and:

350.23 (1) specify the parts of the correction order that are alleged to be in error;

350.24 (2) explain why they are in error; and

350.25 (3) include documentation to support the allegation of error.

350.26 A request for reconsideration does not stay any provisions or requirements of the
350.27 correction order. The commissioner's disposition of a request for reconsideration is final
350.28 and not subject to appeal under chapter 14.

350.29 (b) This paragraph applies only to licensed family child care providers. A licensed family
350.30 child care provider who requests reconsideration of a correction order under paragraph (a)

351.1 may also request, on a form and in the manner prescribed by the commissioner, that the
351.2 commissioner expedite the review if:

351.3 (1) the provider is challenging a violation and provides a description of how complying
351.4 with the corrective action for that violation would require the substantial expenditure of
351.5 funds or a significant change to their program; and

351.6 (2) describes what actions the provider will take in lieu of the corrective action ordered
351.7 to ensure the health and safety of children in care pending the commissioner's review of the
351.8 correction order.

351.9 (c) By January 1, 2018, and each year thereafter, the Department of Human Services
351.10 must report data to the chairs and ranking minority members of the legislative committees
351.11 with jurisdiction over human services policy from the previous year that includes:

351.12 (1) the number of licensed family child care provider appeals of correction orders to the
351.13 Department of Human Services;

351.14 (2) the number of correction order appeals by family child care providers that the
351.15 Department of Human Services grants; and

351.16 (3) the number of correction order appeals that the Department of Human Services
351.17 denies.

351.18 Sec. 6. Minnesota Statutes 2016, section 245A.07, subdivision 3, is amended to read:

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

351.21 (1) a license holder fails to comply fully with applicable laws or rules;

351.22 (2) a license holder, a controlling individual, or an individual living in the household
351.23 where the licensed services are provided or is otherwise subject to a background study has
351.24 a disqualification which has not been set aside under section 245C.22;

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

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

352.1 A license holder who has had a license suspended, revoked, or has been ordered to pay
352.2 a fine must be given notice of the action by certified mail or personal service. If mailed, the
352.3 notice must be mailed to the address shown on the application or the last known address of
352.4 the license holder. The notice must state the reasons the license was suspended, revoked,
352.5 or a fine was ordered.

352.6 (b) If the license was suspended or revoked, the notice must inform the license holder
352.7 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
352.8 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
352.9 a license. The appeal of an order suspending or revoking a license must be made in writing
352.10 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
352.11 the commissioner within ten calendar days after the license holder receives notice that the
352.12 license has been suspended or revoked. If a request is made by personal service, it must be
352.13 received by the commissioner within ten calendar days after the license holder received the
352.14 order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a
352.15 timely appeal of an order suspending or revoking a license, the license holder may continue
352.16 to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and
352.17 (h), until the commissioner issues a final order on the suspension or revocation.

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

352.26 (2) The license holder shall pay the fines assessed on or before the payment date specified.
352.27 If the license holder fails to fully comply with the order, the commissioner may issue a
352.28 second fine or suspend the license until the license holder complies. If the license holder
352.29 receives state funds, the state, county, or municipal agencies or departments responsible for
352.30 administering the funds shall withhold payments and recover any payments made while the
352.31 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine
352.32 until the commissioner issues a final order.

352.33 (3) A license holder shall promptly notify the commissioner of human services, in writing,
352.34 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the
352.35 commissioner determines that a violation has not been corrected as indicated by the order

353.1 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify
353.2 the license holder by certified mail or personal service that a second fine has been assessed.
353.3 The license holder may appeal the second fine as provided under this subdivision.

353.4 (4) Fines shall be assessed as follows:

353.5 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
353.6 child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557
353.7 for which the license holder is determined responsible for the maltreatment under section
353.8 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

353.9 (ii) if the commissioner determines that a determination of maltreatment for which the
353.10 license holder is responsible is the result of maltreatment that meets the definition of serious
353.11 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
353.12 \$5,000;

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

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

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

353.22 For purposes of this section, "occurrence" means each violation identified in the
353.23 commissioner's fine order. Fines assessed against a license holder that holds a license to
353.24 provide home and community-based services, as identified in section 245D.03, subdivision
353.25 1, and a community residential setting or day services facility license under chapter 245D
353.26 where the services are provided, may be assessed against both licenses for the same
353.27 occurrence, but the combined amount of the fines shall not exceed the amount specified in
353.28 this clause for that occurrence.

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

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

354.9 **EFFECTIVE DATE.** This section is effective August 1, 2017.

354.10 **Sec. 7. [245A.1434] INFORMATION FOR CHILD CARE LICENSE HOLDERS.**

354.11 The commissioner shall inform family child care and child care center license holders
 354.12 on a timely basis of changes to state and federal statute, rule, regulation, and policy relating
 354.13 to the provision of licensed child care, the child care assistance program under chapter 119B,
 354.14 the quality rating and improvement system under section 124D.142, and child care licensing
 354.15 functions delegated to counties. Communications under this section shall include information
 354.16 to promote license holder compliance with identified changes. Communications under this
 354.17 section may be accomplished by electronic means and shall be made available to the public
 354.18 online.

354.19 Sec. 8. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

354.20 Subd. 3c. **Local welfare agency, Department of Human Services or Department of**
 354.21 **Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~
 354.22 local welfare agency is the agency responsible for assessing or investigating allegations of
 354.23 maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child
 354.24 care, ~~juvenile correctional facilities licensed under section 241.021 located in the local~~
 354.25 ~~welfare agency's county,~~ and reports involving children served by an unlicensed personal
 354.26 care provider organization under section 256B.0659. Copies of findings related to personal
 354.27 care provider organizations under section 256B.0659 must be forwarded to the Department
 354.28 of Human Services provider enrollment.

354.29 (b) The Department of Human Services is the agency responsible for assessing or
 354.30 investigating allegations of maltreatment in juvenile correctional facilities listed under
 354.31 section 241.021 located in the local welfare agency's county and in facilities licensed or
 354.32 certified under chapters 245A and 245D, except for child foster care and family child care.

355.1 (c) The Department of Health is the agency responsible for assessing or investigating
 355.2 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
 355.3 144A.43 to 144A.482.

355.4 ARTICLE 10

355.5 HEALTH DEPARTMENT

355.6 Section 1. Minnesota Statutes 2016, section 103I.101, subdivision 2, is amended to read:

355.7 Subd. 2. **Duties.** The commissioner shall:

355.8 (1) regulate the drilling, construction, modification, repair, and sealing of wells and
 355.9 borings;

355.10 (2) examine and license:

355.11 (i) well contractors;

355.12 (ii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

355.13 (iii) persons modifying or repairing well casings, well screens, or well diameters;

355.14 (iv) persons constructing, repairing, and sealing drive point wells or dug wells;

355.15 (v) persons installing well pumps or pumping equipment;

355.16 (vi) persons constructing, repairing, and sealing dewatering wells;

355.17 (vii) persons sealing wells; ~~persons installing well pumps or pumping equipment or~~

355.18 borings; and

355.19 (viii) persons excavating or drilling holes for the installation of elevator borings or

355.20 ~~hydraulic cylinders;~~

355.21 (3) ~~register~~ license and examine monitoring well contractors;

355.22 (4) license explorers engaged in exploratory boring and examine individuals who

355.23 supervise or oversee exploratory boring;

355.24 (5) after consultation with the commissioner of natural resources and the Pollution

355.25 Control Agency, establish standards for the design, location, construction, repair, and sealing

355.26 of wells and borings within the state; and

355.27 (6) issue permits for wells, groundwater thermal devices, bored geothermal heat

355.28 exchangers, and elevator borings.

356.1 Sec. 2. Minnesota Statutes 2016, section 103I.101, subdivision 5, is amended to read:

356.2 Subd. 5. **Commissioner to adopt rules.** The commissioner shall adopt rules including:

356.3 (1) issuance of licenses for:

356.4 (i) qualified well contractors;

356.5 (ii) persons modifying or repairing well casings, well screens, or well diameters;

356.6 ~~(ii)~~ (iii) persons constructing, repairing, and sealing drive point wells or dug wells;

356.7 ~~(iii)~~ (iv) persons constructing, repairing, and sealing dewatering wells;

356.8 ~~(iv)~~ (v) persons sealing wells or borings;

356.9 ~~(v)~~ (vi) persons installing well pumps or pumping equipment;

356.10 ~~(vi)~~ (vii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

356.11 and

356.12 ~~(vii)~~ (viii) persons constructing, repairing, and sealing elevator borings;

356.13 (2) issuance of ~~registration~~ licenses for monitoring well contractors;

356.14 (3) establishment of conditions for examination and review of applications for license
356.15 and ~~registration~~ certification;

356.16 (4) establishment of conditions for revocation and suspension of license and ~~registration~~
356.17 certification;

356.18 (5) establishment of minimum standards for design, location, construction, repair, and
356.19 sealing of wells and borings to implement the purpose and intent of this chapter;

356.20 (6) establishment of a system for reporting on wells and borings drilled and sealed;

356.21 (7) establishment of standards for the construction, maintenance, sealing, and water
356.22 quality monitoring of wells in areas of known or suspected contamination;

356.23 (8) establishment of wellhead protection measures for wells serving public water supplies;

356.24 (9) establishment of procedures to coordinate collection of well and boring data with
356.25 other state and local governmental agencies;

356.26 (10) establishment of criteria and procedures for submission of well and boring logs,
356.27 formation samples or well or boring cuttings, water samples, or other special information
356.28 required for and water resource mapping; and

357.1 (11) establishment of minimum standards for design, location, construction, maintenance,
357.2 repair, sealing, safety, and resource conservation related to borings, including exploratory
357.3 borings as defined in section 103I.005, subdivision 9.

357.4 Sec. 3. Minnesota Statutes 2016, section 103I.111, subdivision 6, is amended to read:

357.5 Subd. 6. **Unsealed wells and borings are public health nuisances.** A well or boring
357.6 that is required to be sealed under section 103I.301 but is not sealed is a public health
357.7 nuisance. A county may abate the unsealed well or boring with the same authority of a
357.8 community health board to abate a public health nuisance under section 145A.04, subdivision
357.9 8.

357.10 Sec. 4. Minnesota Statutes 2016, section 103I.111, subdivision 7, is amended to read:

357.11 Subd. 7. **Local license ~~or registration~~ fees prohibited.** (a) A political subdivision may
357.12 not require a licensed well contractor to pay a license ~~or registration~~ fee.

357.13 (b) The commissioner of health must provide a political subdivision with a list of licensed
357.14 well contractors upon request.

357.15 Sec. 5. Minnesota Statutes 2016, section 103I.111, subdivision 8, is amended to read:

357.16 Subd. 8. **Municipal regulation of drilling.** A municipality may regulate all drilling,
357.17 except well, elevator ~~shaft~~ boring, and exploratory drilling that is subject to the provisions
357.18 of this chapter, above, in, through, and adjacent to subsurface areas designated for mined
357.19 underground space development and existing mined underground space. The regulations
357.20 may prohibit, restrict, control, and require permits for the drilling.

357.21 Sec. 6. Minnesota Statutes 2016, section 103I.205, is amended to read:

357.22 **103I.205 WELL AND BORING CONSTRUCTION.**

357.23 Subdivision 1. **Notification required.** (a) Except as provided in paragraphs (d) and (e),
357.24 a person may not construct a well until a notification of the proposed well on a form
357.25 prescribed by the commissioner is filed with the commissioner with the filing fee in section
357.26 103I.208, and, when applicable, the person has met the requirements of paragraph (f). If
357.27 after filing the well notification an attempt to construct a well is unsuccessful, a new
357.28 notification is not required unless the information relating to the successful well has
357.29 substantially changed.

358.1 (b) The property owner, the property owner's agent, or the ~~well~~ licensed contractor where
358.2 a well is to be located must file the well notification with the commissioner.

358.3 (c) The well notification under this subdivision preempts local permits and notifications,
358.4 and counties or home rule charter or statutory cities may not require a permit or notification
358.5 for wells unless the commissioner has delegated the permitting or notification authority
358.6 under section 103I.111.

358.7 (d) A person who is an individual that constructs a drive point water-supply well on
358.8 property owned or leased by the individual for farming or agricultural purposes or as the
358.9 individual's place of abode must notify the commissioner of the installation and location of
358.10 the well. The person must complete the notification form prescribed by the commissioner
358.11 and mail it to the commissioner by ten days after the well is completed. A fee may not be
358.12 charged for the notification. A person who sells drive point wells at retail must provide
358.13 buyers with notification forms and informational materials including requirements regarding
358.14 wells, their location, construction, and disclosure. The commissioner must provide the
358.15 notification forms and informational materials to the sellers.

358.16 (e) A person may not construct a monitoring well until a permit is issued by the
358.17 commissioner for the construction. If after obtaining a permit an attempt to construct a well
358.18 is unsuccessful, a new permit is not required as long as the initial permit is modified to
358.19 indicate the location of the successful well.

358.20 (f) When the operation of a well will require an appropriation permit from the
358.21 commissioner of natural resources, a person may not begin construction of the well until
358.22 the person submits the following information to the commissioner of natural resources:

358.23 (1) the location of the well;

358.24 (2) the formation or aquifer that will serve as the water source;

358.25 (3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be
358.26 requested in the appropriation permit; and

358.27 (4) other information requested by the commissioner of natural resources that is necessary
358.28 to conduct the preliminary assessment required under section 103G.287, subdivision 1,
358.29 paragraph (c).

358.30 The person may begin construction after receiving preliminary approval from the
358.31 commissioner of natural resources.

359.1 Subd. 2. **Emergency permit and notification exemptions.** The commissioner may
359.2 adopt rules that modify the procedures for filing a well or boring notification or well or
359.3 boring permit if conditions occur that:

359.4 (1) endanger the public health and welfare or cause a need to protect the groundwater;
359.5 or

359.6 (2) require the monitoring well contractor, limited well/boring contractor, or well
359.7 contractor to begin constructing a well before obtaining a permit or notification.

359.8 Subd. 3. **Maintenance permit.** (a) Except as provided under paragraph (b), a well that
359.9 is not in use must be sealed or have a maintenance permit.

359.10 (b) If a monitoring well or a dewatering well is not sealed by 14 months after completion
359.11 of construction, the owner of the property on which the well is located must obtain and
359.12 annually renew a maintenance permit from the commissioner.

359.13 Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e),
359.14 section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct,
359.15 repair, or seal a well or boring unless the person has a well contractor's license in possession.

359.16 (b) A person may construct, repair, and seal a monitoring well if the person:

359.17 (1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches
359.18 of civil or geological engineering;

359.19 (2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

359.20 (3) is a professional geoscientist licensed under sections 326.02 to 326.15;

359.21 (4) is a geologist certified by the American Institute of Professional Geologists; or

359.22 (5) meets the qualifications established by the commissioner in rule.

359.23 A person must ~~register with~~ be licensed by the commissioner as a monitoring well
359.24 contractor on forms provided by the commissioner.

359.25 (c) A person may do the following work with a limited well/boring contractor's license
359.26 in possession. A separate license is required for each of the six activities:

359.27 (1) installing or repairing well screens or pitless units or pitless adaptors and well casings
359.28 from the pitless adaptor or pitless unit to the upper termination of the well casing;

359.29 (2) constructing, repairing, and sealing drive point wells or dug wells;

359.30 (3) installing well pumps or pumping equipment;

360.1 (4) sealing wells or borings;

360.2 (5) constructing, repairing, or sealing dewatering wells; or

360.3 (6) constructing, repairing, or sealing bored geothermal heat exchangers.

360.4 (d) A person may construct, repair, and seal an elevator boring with an elevator boring
360.5 contractor's license.

360.6 (e) Notwithstanding other provisions of this chapter requiring a license ~~or registration~~,
360.7 a license ~~or registration~~ is not required for a person who complies with the other provisions
360.8 of this chapter if the person is:

360.9 (1) an individual who constructs a well on land that is owned or leased by the individual
360.10 and is used by the individual for farming or agricultural purposes or as the individual's place
360.11 of abode;

360.12 (2) an individual who performs labor or services for a contractor licensed ~~or registered~~
360.13 under the provisions of this chapter in connection with the construction, sealing, or repair
360.14 of a well or boring at the direction and under the personal supervision of a contractor licensed
360.15 ~~or registered~~ under the provisions of this chapter; or

360.16 (3) a licensed plumber who is repairing submersible pumps or water pipes associated
360.17 with well water systems if: (i) the repair location is within an area where there is no licensed
360.18 ~~or registered~~ well contractor within 50 miles, and (ii) the licensed plumber complies with
360.19 all relevant sections of the plumbing code.

360.20 Subd. 5. **At-grade monitoring wells.** At-grade monitoring wells are authorized without
360.21 variance and may be installed for the purpose of evaluating groundwater conditions or for
360.22 use as a leak detection device. An at-grade monitoring well must be installed in accordance
360.23 with the rules of the commissioner. The at-grade monitoring wells must be installed with
360.24 an impermeable double locking cap approved by the commissioner and must be labeled
360.25 monitoring wells.

360.26 Subd. 6. **Distance requirements for sources of contamination, buildings, gas pipes,**
360.27 **liquid propane tanks, and electric lines.** (a) A person may not place, construct, or install
360.28 an actual or potential source of contamination, building, gas pipe, liquid propane tank, or
360.29 electric line any closer to a well or boring than the isolation distances prescribed by the
360.30 commissioner by rule unless a variance has been prescribed by rule.

360.31 (b) The commissioner shall establish by rule reduced isolation distances for facilities
360.32 which have safeguards in accordance with sections 18B.01, subdivision 26, and 18C.005,
360.33 subdivision 29.

361.1 Subd. 7. **Well identification label required.** After a well has been constructed, the
361.2 person constructing the well must attach a label to the well showing the unique well number.

361.3 Subd. 8. **Wells on property of another.** A person may not construct or have constructed
361.4 a well for the person's own use on the property of another until the owner of the property
361.5 on which the well is to be located and the intended well user sign a written agreement that
361.6 identifies which party will be responsible for obtaining all permits or filing notification,
361.7 paying applicable fees and for sealing the well. If the property owner refuses to sign the
361.8 agreement, the intended well user may, in lieu of a written agreement, state in writing to
361.9 the commissioner that the well user will be responsible for obtaining permits, filing
361.10 notification, paying applicable fees, and sealing the well. Nothing in this subdivision
361.11 eliminates the responsibilities of the property owner under this chapter, or allows a person
361.12 to construct a well on the property of another without consent or other legal authority.

361.13 Subd. 9. **Report of work.** Within 30 days after completion or sealing of a well or boring,
361.14 the person doing the work must submit a verified report to the commissioner containing the
361.15 information specified by rules adopted under this chapter.

361.16 Within 30 days after receiving the report, the commissioner shall send or otherwise
361.17 provide access to a copy of the report to the commissioner of natural resources, to the local
361.18 soil and water conservation district where the well is located, and to the director of the
361.19 Minnesota Geological Survey.

361.20 Sec. 7. Minnesota Statutes 2016, section 103I.301, is amended to read:

361.21 **103I.301 WELL AND BORING SEALING REQUIREMENTS.**

361.22 Subdivision 1. **Wells and borings.** (a) A property owner must have a well or boring
361.23 sealed if:

361.24 (1) the well or boring is contaminated or may contribute to the spread of contamination;

361.25 (2) the well or boring was attempted to be sealed but was not sealed according to the
361.26 provisions of this chapter; or

361.27 (3) the well or boring is located, constructed, or maintained in a manner that its continued
361.28 use or existence endangers groundwater quality or is a safety or health hazard.

361.29 (b) A well or boring that is not in use must be sealed unless the property owner has a
361.30 maintenance permit for the well.

361.31 (c) The property owner must have a well or boring sealed by a ~~registered~~ or licensed
361.32 person authorized to seal the well or boring, consistent with provisions of this chapter.

362.1 Subd. 2. **Monitoring wells.** The owner of the property where a monitoring well is located
 362.2 must have the monitoring well sealed when the well is no longer in use. The owner must
 362.3 have a well contractor, limited well/boring sealing contractor, or a monitoring well contractor
 362.4 seal the monitoring well.

362.5 Subd. 3. **Dewatering wells.** (a) The owner of the property where a dewatering well is
 362.6 located must have the dewatering well sealed when the dewatering well is no longer in use.

362.7 (b) A well contractor, limited well/boring sealing contractor, or limited dewatering well
 362.8 contractor shall seal the dewatering well.

362.9 Subd. 4. **Sealing procedures.** Wells and borings must be sealed according to rules
 362.10 adopted by the commissioner.

362.11 Subd. 6. **Notification required.** A person may not seal a well until a notification of the
 362.12 proposed sealing is filed as prescribed by the commissioner.

362.13 Sec. 8. Minnesota Statutes 2016, section 103I.501, is amended to read:

362.14 **103I.501 LICENSING AND REGULATION OF WELLS AND BORINGS.**

362.15 (a) The commissioner shall regulate and license:

362.16 (1) drilling, constructing, and repair of wells;

362.17 (2) sealing of wells;

362.18 (3) installing of well pumps and pumping equipment;

362.19 (4) excavating, drilling, repairing, and sealing of elevator borings;

362.20 (5) construction, repair, and sealing of environmental bore holes; and

362.21 (6) construction, repair, and sealing of bored geothermal heat exchangers.

362.22 (b) The commissioner shall examine and license well contractors, limited well/boring
 362.23 contractors, ~~and~~ elevator boring contractors, and ~~examine and register~~ monitoring well
 362.24 contractors.

362.25 (c) The commissioner shall license explorers engaged in exploratory boring and shall
 362.26 examine persons who supervise or oversee exploratory boring.

362.27 Sec. 9. Minnesota Statutes 2016, section 103I.505, is amended to read:

362.28 **103I.505 RECIPROCITY OF LICENSES AND REGISTRATIONS**
 362.29 **CERTIFICATIONS.**

363.1 Subdivision 1. **Reciprocity authorized.** The commissioner may issue a license or ~~register~~
363.2 certify a person under this chapter, without giving an examination, if the person is licensed
363.3 or ~~registered~~ certified in another state and:

363.4 (1) the requirements for licensing or ~~registration~~ certification under which the well or
363.5 boring contractor was licensed or ~~registered~~ person was certified do not conflict with this
363.6 chapter;

363.7 (2) the requirements are of a standard not lower than that specified by the rules adopted
363.8 under this chapter; and

363.9 (3) equal reciprocal privileges are granted to licensees or ~~registrants~~ certified persons
363.10 of this state.

363.11 Subd. 2. **Fees required.** A well or boring contractor or certified person must apply for
363.12 the license or ~~registration~~ certification and pay the fees under the provisions of this chapter
363.13 to receive a license or ~~registration~~ certification under this section.

363.14 Sec. 10. Minnesota Statutes 2016, section 103I.515, is amended to read:

363.15 **103I.515 LICENSES NOT TRANSFERABLE.**

363.16 A license or ~~registration~~ certification issued under this chapter is not transferable.

363.17 Sec. 11. Minnesota Statutes 2016, section 103I.535, subdivision 3, is amended to read:

363.18 Subd. 3. **Certification examination.** After the commissioner has approved the
363.19 application, the applicant must take an examination given by the commissioner.

363.20 Sec. 12. Minnesota Statutes 2016, section 103I.535, is amended by adding a subdivision
363.21 to read:

363.22 **Subd. 3b. Certification renewal.** (a) A representative must file an application and a
363.23 renewal application fee to renew the certification by the date stated in the certification.

363.24 (b) The renewal application must include information that the certified representative
363.25 has met continuing education requirements established by the commissioner by rule.

363.26 Sec. 13. Minnesota Statutes 2016, section 103I.535, subdivision 6, is amended to read:

363.27 Subd. 6. **License fee.** The fee for an elevator ~~shaft~~ boring contractor's license is \$75.

364.1 Sec. 14. Minnesota Statutes 2016, section 103I.541, is amended to read:

364.2 **103I.541 MONITORING WELL CONTRACTOR'S REGISTRATION LICENSE;**
 364.3 **REPRESENTATIVE'S CERTIFICATION.**

364.4 Subdivision 1. **Registration Certification.** A person seeking ~~registration as~~ certification
 364.5 to represent a monitoring well contractor must meet examination and experience requirements
 364.6 adopted by the commissioner by rule.

364.7 Subd. 2. **Validity.** A monitoring well contractor's ~~registration~~ certification is valid until
 364.8 the date prescribed in the ~~registration~~ certification by the commissioner.

364.9 Subd. 2a. **Certification application.** (a) An individual must submit an application and
 364.10 application fee to the commissioner to apply for certification as a representative of a
 364.11 monitoring well contractor.

364.12 (b) The application must be on forms prescribed by the commissioner. The application
 364.13 must state the applicant's qualifications for the certification, and other information required
 364.14 by the commissioner.

364.15 ~~Subd. 2b. **Issuance of registration.** If a person employs a certified representative,~~
 364.16 ~~submits the bond under subdivision 3, and pays the registration fee of \$75 for a monitoring~~
 364.17 ~~well contractor registration, the commissioner shall issue a monitoring well contractor~~
 364.18 ~~registration to the applicant. The fee for an individual registration is \$75. The commissioner~~
 364.19 ~~may not act on an application until the application fee is paid.~~

364.20 Subd. 2c. **Certification fee.** (a) The application fee for certification as a representative
 364.21 of a monitoring well contractor is \$75. The commissioner may not act on an application
 364.22 until the application fee is paid.

364.23 (b) The renewal fee for certification as a representative of a monitoring well contractor
 364.24 is \$75. The commissioner may not renew a certification until the renewal fee is paid.

364.25 Subd. 2d. **Examination.** After the commissioner has approved an application, the
 364.26 applicant must take an examination given by the commissioner.

364.27 Subd. 2e. **Issuance of certification.** If the applicant meets the experience requirements
 364.28 established by rule and passes the examination as determined by the commissioner, the
 364.29 commissioner shall issue the applicant a certification to represent a monitoring well
 364.30 contractor.

364.31 Subd. 2f. **Certification renewal.** (a) A representative must file an application and a
 364.32 renewal application fee to renew the certification by the date stated in the certification.

365.1 (b) The renewal application must include information that the certified representative
365.2 has met continuing education requirements established by the commissioner by rule.

365.3 Subd. 2g. **Issuance of license.** (a) If a person employs a certified representative, submits
365.4 the bond under subdivision 3, and pays the license fee of \$75 for a monitoring well contractor
365.5 license, the commissioner shall issue a monitoring well contractor license to the applicant.

365.6 (b) The commissioner may not act on an application until the application fee is paid.

365.7 Subd. 3. **Bond.** (a) As a condition of being issued a monitoring well contractor's
365.8 ~~registration~~ license, the applicant must submit a corporate surety bond for \$10,000 approved
365.9 by the commissioner. The bond must be conditioned to pay the state on performance of
365.10 work in this state that is not in compliance with this chapter or rules adopted under this
365.11 chapter. The bond is in lieu of other license bonds required by a political subdivision of the
365.12 state.

365.13 (b) From proceeds of the bond, the commissioner may compensate persons injured or
365.14 suffering financial loss because of a failure of the applicant to perform work or duties in
365.15 compliance with this chapter or rules adopted under this chapter.

365.16 Subd. 4. **License renewal.** (a) A person must file an application and a renewal application
365.17 fee to renew the ~~registration~~ license by the date stated in the ~~registration~~ license.

365.18 (b) The renewal application fee for a monitoring well contractor's ~~registration~~ license is
365.19 \$75.

365.20 (c) The renewal application must include information that the certified representative
365.21 of the applicant has met continuing education requirements established by the commissioner
365.22 by rule.

365.23 (d) At the time of the renewal, the commissioner must have on file all well and boring
365.24 construction reports, well and boring sealing reports, well permits, and notifications for
365.25 work conducted by the ~~registered~~ licensed person since the last ~~registration~~ license renewal.

365.26 Subd. 5. **Incomplete or late renewal.** If a ~~registered~~ licensed person submits a renewal
365.27 application after the required renewal date:

365.28 (1) the ~~registered~~ licensed person must include a late fee of \$75; and

365.29 (2) the ~~registered~~ licensed person may not conduct activities authorized by the monitoring
365.30 well contractor's ~~registration~~ license until the renewal application, renewal application fee,
365.31 late fee, and all other information required in subdivision 4 are submitted.

366.1 Sec. 15. Minnesota Statutes 2016, section 103I.545, subdivision 1, is amended to read:

366.2 Subdivision 1. **Drilling machine.** (a) A person may not use a drilling machine such as
366.3 a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license
366.4 ~~or registration~~ under this chapter unless the drilling machine is registered with the
366.5 commissioner.

366.6 (b) A person must apply for the registration on forms prescribed by the commissioner
366.7 and submit a \$75 registration fee.

366.8 (c) A registration is valid for one year.

366.9 Sec. 16. Minnesota Statutes 2016, section 103I.545, subdivision 2, is amended to read:

366.10 Subd. 2. **Hoist.** (a) A person may not use a machine such as a hoist for an activity
366.11 requiring a license ~~or registration~~ under this chapter to repair wells or borings, seal wells
366.12 or borings, or install pumps unless the machine is registered with the commissioner.

366.13 (b) A person must apply for the registration on forms prescribed by the commissioner
366.14 and submit a \$75 registration fee.

366.15 (c) A registration is valid for one year.

366.16 Sec. 17. Minnesota Statutes 2016, section 103I.711, subdivision 1, is amended to read:

366.17 Subdivision 1. **Impoundment.** The commissioner may apply to district court for a
366.18 warrant authorizing seizure and impoundment of all drilling machines or hoists owned or
366.19 used by a person. The court shall issue an impoundment order upon the commissioner's
366.20 showing that a person is constructing, repairing, or sealing wells or borings or installing
366.21 pumps or pumping equipment or excavating holes for installing elevator ~~shafts~~ borings
366.22 without a license ~~or registration~~ as required under this chapter. A sheriff on receipt of the
366.23 warrant must seize and impound all drilling machines and hoists owned or used by the
366.24 person. A person from whom equipment is seized under this subdivision may file an action
366.25 in district court for the purpose of establishing that the equipment was wrongfully seized.

366.26 Sec. 18. Minnesota Statutes 2016, section 103I.715, subdivision 2, is amended to read:

366.27 Subd. 2. **Gross misdemeanors.** A person is guilty of a gross misdemeanor who:

366.28 (1) willfully violates a provision of this chapter or order of the commissioner;

367.1 (2) engages in the business of drilling or making wells, sealing wells, installing pumps
 367.2 or pumping equipment, or constructing elevator ~~shafts~~ borings without a license required
 367.3 by this chapter; or

367.4 (3) engages in the business of exploratory boring without an exploratory borer's license
 367.5 under this chapter.

367.6 Sec. 19. Minnesota Statutes 2016, section 144.05, subdivision 6, is amended to read:

367.7 Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The
 367.8 commissioner of health shall provide quarterly reports to the chairs and ranking minority
 367.9 members of the legislative committees with jurisdiction over health and human services
 367.10 policy and finance on:

367.11 (1) interagency agreements or service-level agreements and any renewals or extensions
 367.12 of existing interagency or service-level agreements with a state department under section
 367.13 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of
 367.14 more than \$100,000, or related agreements with the same department or agency with a
 367.15 cumulative value of more than \$100,000; and

367.16 (2) transfers of appropriations of more than \$100,000 between accounts within or between
 367.17 agencies.

367.18 The report must include the statutory citation authorizing the agreement, transfer or dollar
 367.19 amount, purpose, and effective date of the agreement, and the duration of the agreement;
 367.20 ~~and a copy of the agreement.~~

367.21 Sec. 20. **[144.059] PALLIATIVE CARE ADVISORY COUNCIL.**

367.22 Subdivision 1. **Membership.** The Palliative Care Advisory Council shall consist of 18
 367.23 public members.

367.24 Subd. 2. **Public members.** (a) The commissioner shall appoint, in the manner provided
 367.25 in section 15.0597, 18 public members, including the following:

367.26 (1) two physicians, of which one is certified by the American Board of Hospice and
 367.27 Palliative Medicine;

367.28 (2) two registered nurses or advanced practice registered nurses, of which one is certified
 367.29 by the National Board for Certification of Hospice and Palliative Nurses;

367.30 (3) one care coordinator experienced in working with people with serious or chronic
 367.31 illness and their families;

368.1 (4) one spiritual counselor experienced in working with people with serious or chronic
368.2 illness and their families;

368.3 (5) three licensed health professionals, such as complementary and alternative health
368.4 care practitioners, dieticians or nutritionists, pharmacists, or physical therapists, who are
368.5 neither physicians nor nurses, but who have experience as members of a palliative care
368.6 interdisciplinary team working with people with serious or chronic illness and their families;

368.7 (6) one licensed social worker experienced in working with people with serious or chronic
368.8 illness and their families;

368.9 (7) four patients or personal caregivers experienced with serious or chronic illness;

368.10 (8) one representative of a health plan company;

368.11 (9) one physician assistant that is a member of the American Academy of Hospice and
368.12 Palliative Medicine; and

368.13 (10) two members from any of the categories described in clauses (1) to (9).

368.14 (b) The commissioner must include, where possible, representation that is racially,
368.15 culturally, linguistically, geographically, and economically diverse.

368.16 (c) The council must include at least six members who reside outside Anoka, Carver,
368.17 Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Sibley, Stearns,
368.18 Washington, or Wright Counties.

368.19 (d) To the extent possible, council membership must include persons who have experience
368.20 in palliative care research, palliative care instruction in a medical or nursing school setting,
368.21 palliative care services for veterans as a provider or recipient, or pediatric care.

368.22 (e) Council membership must include health professionals who have palliative care work
368.23 experience or expertise in palliative care delivery models in a variety of inpatient, outpatient,
368.24 and community settings, including acute care, long-term care, or hospice, with a variety of
368.25 populations, including pediatric, youth, and adult patients.

368.26 Subd. 3. **Term.** Members of the council shall serve for a term of three years and may
368.27 be reappointed. Members shall serve until their successors have been appointed.

368.28 Subd. 4. **Administration.** The commissioner or the commissioner's designee shall
368.29 provide meeting space and administrative services for the council.

368.30 Subd. 5. **Chairs.** At the council's first meeting, and biannually thereafter, the members
368.31 shall elect a chair and a vice-chair whose duties shall be established by the council.

369.1 Subd. 6. Meeting. The council shall meet at least twice yearly.

369.2 Subd. 7. No compensation. Public members of the council serve without compensation.

369.3 Subd. 8. Duties. (a) The council shall consult with and advise the commissioner on
369.4 matters related to the establishment, maintenance, operation, and outcomes evaluation of
369.5 palliative care initiatives in the state.

369.6 (b) By February 15 of each year, the council shall submit to the chairs and ranking
369.7 minority members of the committees of the senate and the house of representatives with
369.8 primary jurisdiction over health care a report containing:

369.9 (1) the advisory council's assessment of the availability of palliative care in the state;

369.10 (2) the advisory council's analysis of barriers to greater access to palliative care; and

369.11 (3) recommendations for legislative action, with draft legislation to implement the
369.12 recommendations.

369.13 (c) The Department of Health shall publish the report each year on the department's Web
369.14 site.

369.15 Subd. 9. Open meetings. The council is subject to the requirements of chapter 13D.

369.16 Subd. 10. Sunset. The council shall sunset January 1, 2025.

369.17 Sec. 21. Minnesota Statutes 2016, section 144.122, is amended to read:

369.18 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

369.19 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
369.20 filing with the commissioner as prescribed by statute and for the issuance of original and
369.21 renewal permits, licenses, registrations, and certifications issued under authority of the
369.22 commissioner. The expiration dates of the various licenses, permits, registrations, and
369.23 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
369.24 application and examination fees and a penalty fee for renewal applications submitted after
369.25 the expiration date of the previously issued permit, license, registration, and certification.
369.26 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
369.27 registrations, and certifications when the application therefor is submitted during the last
369.28 three months of the permit, license, registration, or certification period. Fees proposed to
369.29 be prescribed in the rules shall be first approved by the Department of Management and
369.30 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
369.31 in an amount so that the total fees collected by the commissioner will, where practical,
369.32 approximate the cost to the commissioner in administering the program. All fees collected

370.1 shall be deposited in the state treasury and credited to the state government special revenue
370.2 fund unless otherwise specifically appropriated by law for specific purposes.

370.3 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
370.4 and environmental laboratories, and for environmental and medical laboratory services
370.5 provided by the department, without complying with paragraph (a) or chapter 14. Fees
370.6 charged for environment and medical laboratory services provided by the department must
370.7 be approximately equal to the costs of providing the services.

370.8 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
370.9 conducted at clinics held by the services for children with disabilities program. All receipts
370.10 generated by the program are annually appropriated to the commissioner for use in the
370.11 maternal and child health program.

370.12 (d) The commissioner shall set license fees for hospitals and nursing homes that are not
370.13 boarding care homes at the following levels:

370.14	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
370.15	Healthcare Organizations (JCAHO) and	
370.16	American Osteopathic Association (AOA)	
370.17	hospitals	

370.18	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
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370.19	Nursing home	\$183 plus \$91 per bed
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370.20 The commissioner shall set license fees for outpatient surgical centers, boarding care
370.21 homes, and supervised living facilities at the following levels:

370.22	Outpatient surgical centers	\$3,712
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370.23	Boarding care homes	\$183 plus \$91 per bed
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370.24	Supervised living facilities	\$183 plus \$91 per bed.
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370.25 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
370.26 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
370.27 or later.

370.28 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants
370.29 the following fees to cover the cost of any initial certification surveys required to determine
370.30 a provider's eligibility to participate in the Medicare or Medicaid program:

370.31	Prospective payment surveys for hospitals	\$	900
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370.32	Swing bed surveys for nursing homes	\$	1,200
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370.33	Psychiatric hospitals	\$	1,400
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370.34	Rural health facilities	\$	1,100
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370.35	Portable x-ray providers	\$	500
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371.1	Home health agencies	\$	1,800
371.2	Outpatient therapy agencies	\$	800
371.3	End stage renal dialysis providers	\$	2,100
371.4	Independent therapists	\$	800
371.5	Comprehensive rehabilitation outpatient facilities	\$	1,200
371.6	Hospice providers	\$	1,700
371.7	Ambulatory surgical providers	\$	1,800
371.8	Hospitals	\$	4,200

371.9 Other provider categories or additional
 371.10 resurveys required to complete initial
 371.11 certification

Actual surveyor costs: average
 surveyor cost x number of hours for
 the survey process.

371.12 These fees shall be submitted at the time of the application for federal certification and
 371.13 shall not be refunded. All fees collected after the date that the imposition of fees is not
 371.14 prohibited by federal law shall be deposited in the state treasury and credited to the state
 371.15 government special revenue fund.

371.16 Sec. 22. Minnesota Statutes 2016, section 144.1501, subdivision 2, is amended to read:

371.17 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness
 371.18 program account is established. The commissioner of health shall use money from the
 371.19 account to establish a loan forgiveness program:

371.20 (1) for medical residents and mental health professionals agreeing to practice in designated
 371.21 rural areas or underserved urban communities or specializing in the area of pediatric
 371.22 psychiatry;

371.23 (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach
 371.24 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program
 371.25 at the undergraduate level or the equivalent at the graduate level;

371.26 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care
 371.27 facility for persons with developmental disability; ~~or~~ a hospital if the hospital owns and
 371.28 operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by
 371.29 the nurse is in the nursing home; a housing with services establishment as defined in section
 371.30 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43,
 371.31 subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing
 371.32 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
 371.33 level;

372.1 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720
 372.2 hours per year in their designated field in a postsecondary program at the undergraduate
 372.3 level or the equivalent at the graduate level. The commissioner, in consultation with the
 372.4 Healthcare Education-Industry Partnership, shall determine the health care fields where the
 372.5 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory
 372.6 technology, radiologic technology, and surgical technology;

372.7 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses
 372.8 who agree to practice in designated rural areas; and

372.9 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
 372.10 encounters to state public program enrollees or patients receiving sliding fee schedule
 372.11 discounts through a formal sliding fee schedule meeting the standards established by the
 372.12 United States Department of Health and Human Services under Code of Federal Regulations,
 372.13 title 42, section 51, chapter 303.

372.14 (b) Appropriations made to the account do not cancel and are available until expended,
 372.15 except that at the end of each biennium, any remaining balance in the account that is not
 372.16 committed by contract and not needed to fulfill existing commitments shall cancel to the
 372.17 fund.

372.18 Sec. 23. **[144.1505] PRIMARY CARE CLINICAL TRAINING EXPANSION GRANT**
 372.19 **PROGRAM.**

372.20 Subdivision 1. Definitions. For purposes of this section, the following definitions apply:

372.21 (1) "eligible advanced practice registered nurse program" means a program that is located
 372.22 in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level
 372.23 advanced practice registered nurse program by the Commission on Collegiate Nursing
 372.24 Education or by the Accreditation Commission for Education in Nursing, or is a candidate
 372.25 for accreditation;

372.26 (2) "eligible physician assistant program" means a program that is located in Minnesota
 372.27 and is currently accredited as a physician assistant program by the Accreditation Review
 372.28 Commission on Education for the Physician Assistant, or is a candidate for accreditation;
 372.29 and

372.30 (3) "project" means a project to establish or expand clinical training for physician
 372.31 assistants or advanced practice registered nurses in Minnesota.

372.32 Subd. 2. Program. (a) The commissioner of health shall award health professional
 372.33 training site grants to eligible physician assistant and advanced practice registered nurse

373.1 programs to plan and implement expanded clinical training. A planning grant shall not
373.2 exceed \$75,000, and a training grant shall not exceed \$150,000 for the first year, \$100,000
373.3 for the second year, and \$50,000 for the third year per program.

373.4 (b) Funds may be used for:

373.5 (1) establishing or expanding clinical training for physician assistants and advanced
373.6 practice registered nurses in Minnesota;

373.7 (2) recruitment, training, and retention of students and faculty;

373.8 (3) connecting students with appropriate clinical training sites, internships, practicums,
373.9 or externship activities;

373.10 (4) travel and lodging for students;

373.11 (5) faculty, student, and preceptor salaries, incentives, or other financial support;

373.12 (6) development and implementation of cultural competency training;

373.13 (7) evaluations;

373.14 (8) training site improvements, fees, equipment, and supplies required to establish,
373.15 maintain, or expand a physician assistant or advanced practice registered nurse training
373.16 program; and

373.17 (9) supporting clinical education in which trainees are part of a primary care team model.

373.18 Subd. 3. **Applications.** Eligible physician assistant and advanced practice registered
373.19 nurse programs seeking a grant shall apply to the commissioner. Applications must include
373.20 a description of the number of additional students who will be trained using grant funds;
373.21 attestation that funding will be used to support an increase in the number of clinical training
373.22 slots; a description of the problem that the proposed project will address; a description of
373.23 the project, including all costs associated with the project, sources of funds for the project,
373.24 detailed uses of all funds for the project, and the results expected; and a plan to maintain or
373.25 operate any component included in the project after the grant period. The applicant must
373.26 describe achievable objectives, a timetable, and roles and capabilities of responsible
373.27 individuals in the organization.

373.28 Subd. 4. **Consideration of applications.** The commissioner shall review each application
373.29 to determine whether or not the application is complete and whether the program and the
373.30 project are eligible for a grant. In evaluating applications, the commissioner shall score each
373.31 application based on factors including, but not limited to, the applicant's clarity and
373.32 thoroughness in describing the project and the problems to be addressed, the extent to which

374.1 the applicant has demonstrated that the applicant has made adequate provisions to ensure
374.2 proper and efficient operation of the training program once the grant project is completed,
374.3 the extent to which the proposed project is consistent with the goal of increasing access to
374.4 primary care and mental health services for rural and underserved urban communities, the
374.5 extent to which the proposed project incorporates team-based primary care, and project
374.6 costs and use of funds.

374.7 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant
374.8 to be given to an eligible program based on the relative score of each eligible program's
374.9 application, other relevant factors discussed during the review, and the funds available to
374.10 the commissioner. Appropriations made to the program do not cancel and are available until
374.11 expended. During the grant period, the commissioner may require and collect from programs
374.12 receiving grants any information necessary to evaluate the program.

374.13 Sec. 24. Minnesota Statutes 2016, section 144.551, subdivision 1, is amended to read:

374.14 Subdivision 1. **Restricted construction or modification.** (a) The following construction
374.15 or modification may not be commenced:

374.16 (1) any erection, building, alteration, reconstruction, modernization, improvement,
374.17 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
374.18 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
374.19 to another, or otherwise results in an increase or redistribution of hospital beds within the
374.20 state; and

374.21 (2) the establishment of a new hospital.

374.22 (b) This section does not apply to:

374.23 (1) construction or relocation within a county by a hospital, clinic, or other health care
374.24 facility that is a national referral center engaged in substantial programs of patient care,
374.25 medical research, and medical education meeting state and national needs that receives more
374.26 than 40 percent of its patients from outside the state of Minnesota;

374.27 (2) a project for construction or modification for which a health care facility held an
374.28 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
374.29 certificate;

374.30 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
374.31 appeal results in an order reversing the denial;

375.1 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
375.2 section 2;

375.3 (5) a project involving consolidation of pediatric specialty hospital services within the
375.4 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
375.5 of pediatric specialty hospital beds among the hospitals being consolidated;

375.6 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
375.7 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
375.8 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
375.9 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
375.10 hospitals must be reinstated at the capacity that existed on each site before the relocation;

375.11 (7) the relocation or redistribution of hospital beds within a hospital building or
375.12 identifiable complex of buildings provided the relocation or redistribution does not result
375.13 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
375.14 one physical site or complex to another; or (iii) redistribution of hospital beds within the
375.15 state or a region of the state;

375.16 (8) relocation or redistribution of hospital beds within a hospital corporate system that
375.17 involves the transfer of beds from a closed facility site or complex to an existing site or
375.18 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
375.19 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
375.20 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
375.21 health systems agency boundary in place on July 1, 1983; and (iv) the relocation or
375.22 redistribution does not involve the construction of a new hospital building;

375.23 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
375.24 County that primarily serves adolescents and that receives more than 70 percent of its
375.25 patients from outside the state of Minnesota;

375.26 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
375.27 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
375.28 and (ii) the total licensed capacity of the replacement hospital, either at the time of
375.29 construction of the initial building or as the result of future expansion, will not exceed 70
375.30 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

375.31 (11) the relocation of licensed hospital beds from an existing state facility operated by
375.32 the commissioner of human services to a new or existing facility, building, or complex
375.33 operated by the commissioner of human services; from one regional treatment center site

376.1 to another; or from one building or site to a new or existing building or site on the same
376.2 campus;

376.3 (12) the construction or relocation of hospital beds operated by a hospital having a
376.4 statutory obligation to provide hospital and medical services for the indigent that does not
376.5 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
376.6 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
376.7 Medical Center to Regions Hospital under this clause;

376.8 (13) a construction project involving the addition of up to 31 new beds in an existing
376.9 nonfederal hospital in Beltrami County;

376.10 (14) a construction project involving the addition of up to eight new beds in an existing
376.11 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

376.12 (15) a construction project involving the addition of 20 new hospital beds used for
376.13 rehabilitation services in an existing hospital in Carver County serving the southwest
376.14 suburban metropolitan area. Beds constructed under this clause shall not be eligible for
376.15 reimbursement under medical assistance or MinnesotaCare;

376.16 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
376.17 of up to two psychiatric facilities or units for children provided that the operation of the
376.18 facilities or units have received the approval of the commissioner of human services;

376.19 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
376.20 services in an existing hospital in Itasca County;

376.21 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
376.22 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
376.23 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
376.24 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

376.25 (19) a critical access hospital established under section 144.1483, clause (9), and section
376.26 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
376.27 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
376.28 to the extent that the critical access hospital does not seek to exceed the maximum number
376.29 of beds permitted such hospital under federal law;

376.30 (20) notwithstanding section 144.552, a project for the construction of a new hospital
376.31 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

377.1 (i) the project, including each hospital or health system that will own or control the entity
377.2 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
377.3 Council as of March 1, 2006;

377.4 (ii) the entity that will hold the new hospital license will be owned or controlled by one
377.5 or more not-for-profit hospitals or health systems that have previously submitted a plan or
377.6 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
377.7 have been found to be in the public interest by the commissioner of health as of April 1,
377.8 2005;

377.9 (iii) the new hospital's initial inpatient services must include, but are not limited to,
377.10 medical and surgical services, obstetrical and gynecological services, intensive care services,
377.11 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
377.12 services, and emergency room services;

377.13 (iv) the new hospital:

377.14 (A) will have the ability to provide and staff sufficient new beds to meet the growing
377.15 needs of the Maple Grove service area and the surrounding communities currently being
377.16 served by the hospital or health system that will own or control the entity that will hold the
377.17 new hospital license;

377.18 (B) will provide uncompensated care;

377.19 (C) will provide mental health services, including inpatient beds;

377.20 (D) will be a site for workforce development for a broad spectrum of health-care-related
377.21 occupations and have a commitment to providing clinical training programs for physicians
377.22 and other health care providers;

377.23 (E) will demonstrate a commitment to quality care and patient safety;

377.24 (F) will have an electronic medical records system, including physician order entry;

377.25 (G) will provide a broad range of senior services;

377.26 (H) will provide emergency medical services that will coordinate care with regional
377.27 providers of trauma services and licensed emergency ambulance services in order to enhance
377.28 the continuity of care for emergency medical patients; and

377.29 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
377.30 the control of the entity holding the new hospital license; and

378.1 (v) as of 30 days following submission of a written plan, the commissioner of health
378.2 has not determined that the hospitals or health systems that will own or control the entity
378.3 that will hold the new hospital license are unable to meet the criteria of this clause;

378.4 (21) a project approved under section 144.553;

378.5 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
378.6 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
378.7 is approved by the Cass County Board;

378.8 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
378.9 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
378.10 a separately licensed 13-bed skilled nursing facility;

378.11 (24) notwithstanding section 144.552, a project for the construction and expansion of a
378.12 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
378.13 who are under 21 years of age on the date of admission. The commissioner conducted a
378.14 public interest review of the mental health needs of Minnesota and the Twin Cities
378.15 metropolitan area in 2008. No further public interest review shall be conducted for the
378.16 construction or expansion project under this clause;

378.17 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
378.18 commissioner finds the project is in the public interest after the public interest review
378.19 conducted under section 144.552 is complete; ~~or~~

378.20 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
378.21 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
378.22 admission, if the commissioner finds the project is in the public interest after the public
378.23 interest review conducted under section 144.552 is complete;

378.24 (ii) this project shall serve patients in the continuing care benefit program under section
378.25 256.9693. The project may also serve patients not in the continuing care benefit program;
378.26 and

378.27 (iii) if the project ceases to participate in the continuing care benefit program, the
378.28 commissioner must complete a subsequent public interest review under section 144.552. If
378.29 the project is found not to be in the public interest, the license must be terminated six months
378.30 from the date of that finding. If the commissioner of human services terminates the contract
378.31 without cause or reduces per diem payment rates for patients under the continuing care
378.32 benefit program below the rates in effect for services provided on December 31, 2015, the

379.1 project may cease to participate in the continuing care benefit program and continue to
 379.2 operate without a subsequent public interest review; or

379.3 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
 379.4 in Hennepin County that is exclusively for patients who are under 21 years of age on the
 379.5 date of admission.

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

379.7 Sec. 25. Minnesota Statutes 2016, section 144A.472, subdivision 7, is amended to read:

379.8 **Subd. 7. Fees; application, change of ownership, and renewal.** (a) An initial applicant
 379.9 seeking temporary home care licensure must submit the following application fee to the
 379.10 commissioner along with a completed application:

379.11 (1) for a basic home care provider, \$2,100; or

379.12 (2) for a comprehensive home care provider, \$4,200.

379.13 (b) A home care provider who is filing a change of ownership as required under
 379.14 subdivision 5 must submit the following application fee to the commissioner, along with
 379.15 the documentation required for the change of ownership:

379.16 (1) for a basic home care provider, \$2,100; or

379.17 (2) for a comprehensive home care provider, \$4,200.

379.18 (c) A home care provider who is seeking to renew the provider's license shall pay a fee
 379.19 to the commissioner based on revenues derived from the provision of home care services
 379.20 during the calendar year prior to the year in which the application is submitted, according
 379.21 to the following schedule:

379.22 License Renewal Fee

379.23 Provider Annual Revenue	Fee
379.24 greater than \$1,500,000	\$6,625
379.25 greater than \$1,275,000 and no more than 379.26 \$1,500,000	\$5,797
379.27 greater than \$1,100,000 and no more than 379.28 \$1,275,000	\$4,969
379.29 greater than \$950,000 and no more than 379.30 \$1,100,000	\$4,141
379.31 greater than \$850,000 and no more than \$950,000	\$3,727
379.32 greater than \$750,000 and no more than \$850,000	\$3,313
379.33 greater than \$650,000 and no more than \$750,000	\$2,898

380.1	greater than \$550,000 and no more than \$650,000	\$2,485
380.2	greater than \$450,000 and no more than \$550,000	\$2,070
380.3	greater than \$350,000 and no more than \$450,000	\$1,656
380.4	greater than \$250,000 and no more than \$350,000	\$1,242
380.5	greater than \$100,000 and no more than \$250,000	\$828
380.6	greater than \$50,000 and no more than \$100,000	\$500
380.7	greater than \$25,000 and no more than \$50,000	\$400
380.8	no more than \$25,000	\$200

380.9 (d) If requested, the home care provider shall provide the commissioner information to
 380.10 verify the provider's annual revenues or other information as needed, including copies of
 380.11 documents submitted to the Department of Revenue.

380.12 (e) At each annual renewal, a home care provider may elect to pay the highest renewal
 380.13 fee for its license category, and not provide annual revenue information to the commissioner.

380.14 (f) A temporary license or license applicant, or temporary licensee or licensee that
 380.15 knowingly provides the commissioner incorrect revenue amounts for the purpose of paying
 380.16 a lower license fee, shall be subject to a civil penalty in the amount of double the fee the
 380.17 provider should have paid.

380.18 (g) Fees and penalties collected under this section shall be deposited in the state treasury
 380.19 and credited to the state government special revenue fund. All fees are nonrefundable. Fees
 380.20 collected under paragraph (c) are nonrefundable even if received before July 1, 2017, for
 380.21 temporary licenses or licenses being issued effective July 1, 2017, or later.

380.22 (h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

380.23 Sec. 26. Minnesota Statutes 2016, section 144A.474, subdivision 11, is amended to read:

380.24 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed
 380.25 based on the level and scope of the violations described in paragraph (c) as follows:

380.26 (1) Level 1, no fines or enforcement;

380.27 (2) Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement
 380.28 mechanisms authorized in section 144A.475 for widespread violations;

380.29 (3) Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement
 380.30 mechanisms authorized in section 144A.475; and

380.31 (4) Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the enforcement
 380.32 mechanisms authorized in section 144A.475.

381.1 (b) Correction orders for violations are categorized by both level and scope and fines
381.2 shall be assessed as follows:

381.3 (1) level of violation:

381.4 (i) Level 1 is a violation that has no potential to cause more than a minimal impact on
381.5 the client and does not affect health or safety;

381.6 (ii) Level 2 is a violation that did not harm a client's health or safety but had the potential
381.7 to have harmed a client's health or safety, but was not likely to cause serious injury,
381.8 impairment, or death;

381.9 (iii) Level 3 is a violation that harmed a client's health or safety, not including serious
381.10 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
381.11 impairment, or death; and

381.12 (iv) Level 4 is a violation that results in serious injury, impairment, or death.

381.13 (2) scope of violation:

381.14 (i) isolated, when one or a limited number of clients are affected or one or a limited
381.15 number of staff are involved or the situation has occurred only occasionally;

381.16 (ii) pattern, when more than a limited number of clients are affected, more than a limited
381.17 number of staff are involved, or the situation has occurred repeatedly but is not found to be
381.18 pervasive; and

381.19 (iii) widespread, when problems are pervasive or represent a systemic failure that has
381.20 affected or has the potential to affect a large portion or all of the clients.

381.21 (c) If the commissioner finds that the applicant or a home care provider required to be
381.22 licensed under sections 144A.43 to 144A.482 has not corrected violations by the date
381.23 specified in the correction order or conditional license resulting from a survey or complaint
381.24 investigation, the commissioner may impose a fine. A notice of noncompliance with a
381.25 correction order must be mailed to the applicant's or provider's last known address. The
381.26 noncompliance notice must list the violations not corrected.

381.27 (d) The license holder must pay the fines assessed on or before the payment date specified.
381.28 If the license holder fails to fully comply with the order, the commissioner may issue a
381.29 second fine or suspend the license until the license holder complies by paying the fine. A
381.30 timely appeal shall stay payment of the fine until the commissioner issues a final order.

381.31 (e) A license holder shall promptly notify the commissioner in writing when a violation
381.32 specified in the order is corrected. If upon reinspection the commissioner determines that

382.1 a violation has not been corrected as indicated by the order, the commissioner may issue a
382.2 second fine. The commissioner shall notify the license holder by mail to the last known
382.3 address in the licensing record that a second fine has been assessed. The license holder may
382.4 appeal the second fine as provided under this subdivision.

382.5 (f) A home care provider that has been assessed a fine under this subdivision has a right
382.6 to a reconsideration or a hearing under this section and chapter 14.

382.7 (g) When a fine has been assessed, the license holder may not avoid payment by closing,
382.8 selling, or otherwise transferring the licensed program to a third party. In such an event, the
382.9 license holder shall be liable for payment of the fine.

382.10 (h) In addition to any fine imposed under this section, the commissioner may assess
382.11 costs related to an investigation that results in a final order assessing a fine or other
382.12 enforcement action authorized by this chapter.

382.13 (i) Fines collected under this subdivision shall be deposited in the state government
382.14 special revenue fund and credited to an account separate from the revenue collected under
382.15 section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines
382.16 collected ~~may~~ must be used by the commissioner for special projects to improve home care
382.17 in Minnesota as recommended by the advisory council established in section 144A.4799.

382.18 Sec. 27. Minnesota Statutes 2016, section 144A.4799, subdivision 3, is amended to read:

382.19 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
382.20 advice regarding regulations of Department of Health licensed home care providers in this
382.21 chapter, including advice on the following:

382.22 (1) community standards for home care practices;

382.23 (2) enforcement of licensing standards and whether certain disciplinary actions are
382.24 appropriate;

382.25 (3) ways of distributing information to licensees and consumers of home care;

382.26 (4) training standards;

382.27 (5) identifying emerging issues and opportunities in the home care field, including the
382.28 use of technology in home and telehealth capabilities;

382.29 (6) allowable home care licensing modifications and exemptions, including a method
382.30 for an integrated license with an existing license for rural licensed nursing homes to provide
382.31 limited home care services in an adjacent independent living apartment building owned by
382.32 the licensed nursing home; and

383.1 (7) recommendations for studies using the data in section 62U.04, subdivision 4, including
383.2 but not limited to studies concerning costs related to dementia and chronic disease among
383.3 an elderly population over 60 and additional long-term care costs, as described in section
383.4 62U.10, subdivision 6.

383.5 (b) The advisory council shall perform other duties as directed by the commissioner.

383.6 (c) The advisory council shall annually review the balance of the account in the state
383.7 government special revenue fund described in section 144A.474, subdivision 11, paragraph
383.8 (i), and make annual recommendations by January 15 directly to the chairs and ranking
383.9 minority members of the legislative committees with jurisdiction over health and human
383.10 services regarding appropriations to the commissioner for the purposes in section 144A.474,
383.11 subdivision 11, paragraph (i).

383.12 Sec. 28. Minnesota Statutes 2016, section 144A.70, is amended by adding a subdivision
383.13 to read:

383.14 Subd. 4a. Nurse. "Nurse" means a licensed practical nurse as defined in section 148.171,
383.15 subdivision 8, or a registered nurse as defined in section 148.171, subdivision 20.

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

383.17 Sec. 29. Minnesota Statutes 2016, section 144A.70, subdivision 6, is amended to read:

383.18 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services
383.19 agency" means a person, firm, corporation, partnership, or association engaged for hire in
383.20 the business of providing or procuring temporary employment in health care facilities for
383.21 nurses, nursing assistants, nurse aides, and orderlies,~~and other licensed health professionals.~~
383.22 Supplemental nursing services agency does not include an individual who only engages in
383.23 providing the individual's services on a temporary basis to health care facilities. Supplemental
383.24 nursing services agency does not include a professional home care agency licensed under
383.25 section 144A.471 that only provides staff to other home care providers.

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

383.27 Sec. 30. Minnesota Statutes 2016, section 144D.06, is amended to read:

383.28 **144D.06 OTHER LAWS.**

383.29 In addition to registration under this chapter, a housing with services establishment must
383.30 comply with chapter 504B and the provisions of section 325F.72, and shall obtain and
383.31 maintain all other licenses, permits, registrations, or other governmental approvals required

384.1 of it ~~in addition to registration under this chapter~~. A housing with services establishment is
 384.2 ~~subject to the provisions of section 325F.72 and chapter 504B~~ not required to obtain a
 384.3 lodging license under chapter 157 and related rules.

384.4 **EFFECTIVE DATE.** This section is effective August 1, 2017.

384.5 Sec. 31. **[144D.071] CHANGE OF LIVING UNIT.**

384.6 Housing with services establishments must not require a resident to move from the
 384.7 resident's living unit to another living unit, to share a unit, or to move out of the building
 384.8 after a resident begins receiving services under section 256B.0915.

384.9 Sec. 32. **[144H.01] DEFINITIONS.**

384.10 Subdivision 1. **Application.** The terms defined in this section apply to this chapter.

384.11 Subd. 2. **Basic services.** "Basic services" includes but is not limited to:

384.12 (1) the development, implementation, and monitoring of a comprehensive protocol of
 384.13 care that is developed in conjunction with the parent or guardian of a medically complex
 384.14 or technologically dependent child and that specifies the medical, nursing, psychosocial,
 384.15 and developmental therapies required by the medically complex or technologically dependent
 384.16 child; and

384.17 (2) the caregiver training needs of the child's parent or guardian.

384.18 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

384.19 Subd. 4. **Licensee.** "Licensee" means an owner of a prescribed pediatric extended care
 384.20 (PPEC) center licensed under this chapter.

384.21 Subd. 5. **Medically complex or technologically dependent child.** "Medically complex
 384.22 or technologically dependent child" means a child who, because of a medical condition,
 384.23 requires continuous therapeutic interventions or skilled nursing supervision which must be
 384.24 prescribed by a licensed physician and administered by, or under the direct supervision of,
 384.25 a licensed registered nurse.

384.26 Subd. 6. **Owner.** "Owner" means an individual whose ownership interest provides
 384.27 sufficient authority or control to affect or change decisions regarding the operation of the
 384.28 PPEC center. An owner includes a sole proprietor, a general partner, or any other individual
 384.29 whose ownership interest has the ability to affect the management and direction of the PPEC
 384.30 center's policies.

385.1 Subd. 7. Prescribed pediatric extended care center, PPEC center, or center.

385.2 "Prescribed pediatric extended care center," "PPEC center," or "center" means any facility
385.3 operated on a for-profit or nonprofit basis to provide nonresidential basic services to three
385.4 or more medically complex or technologically dependent children who require such services
385.5 and who are not related to the owner by blood, marriage, or adoption.

385.6 Subd. 8. Supportive services or contracted services. "Supportive services or contracted
385.7 services" include but are not limited to speech therapy, occupational therapy, physical
385.8 therapy, social work services, developmental services, child life services, and psychology
385.9 services.

385.10 Sec. 33. [144H.02] LICENSURE REQUIRED.

385.11 A person may not own or operate a prescribed pediatric extended care center in this state
385.12 unless the person holds a temporary or current license issued under this chapter. A separate
385.13 license must be obtained for each PPEC center maintained on separate premises, even if
385.14 the same management operates the PPEC centers. Separate licenses are not required for
385.15 separate buildings on the same grounds. A center shall not be operated on the same grounds
385.16 as a child care center licensed under Minnesota Rules, chapter 9503.

385.17 Sec. 34. [144H.03] EXEMPTIONS.

385.18 This chapter does not apply to:

385.19 (1) a facility operated by the United States government or a federal agency; or

385.20 (2) a health care facility licensed under chapter 144 or 144A.

385.21 Sec. 35. [144H.04] LICENSE APPLICATION AND RENEWAL.

385.22 Subdivision 1. Licenses. A person seeking licensure for a PPEC center must submit a
385.23 completed application for licensure to the commissioner, in a form and manner determined
385.24 by the commissioner. The applicant must also submit the application fee, in the amount
385.25 specified in section 144H.05, subdivision 1. Effective February 1, 2019, the commissioner
385.26 shall issue a license for a PPEC center if the commissioner determines that the applicant
385.27 and center meet the requirements of this chapter and rules adopted under this chapter. A
385.28 license issued under this subdivision is valid for two years.

385.29 Subd. 2. License renewal. A license issued under subdivision 1 may be renewed for a
385.30 period of two years if the licensee:

386.1 (1) submits an application for renewal in a form and manner determined by the
386.2 commissioner, at least 30 days before the license expires. An application for renewal
386.3 submitted after the renewal deadline date must be accompanied by a late fee in the amount
386.4 specified in section 144H.05, subdivision 3;

386.5 (2) submits the renewal fee in the amount specified in section 144H.05, subdivision 2;

386.6 (3) demonstrates that the licensee has provided basic services at the PPEC center within
386.7 the past two years;

386.8 (4) provides evidence that the applicant meets the requirements for licensure; and

386.9 (5) provides other information required by the commissioner.

386.10 Subd. 3. **License not transferable.** A PPEC center license issued under this section is
386.11 not transferable to another party. Before acquiring ownership of a PPEC center, a prospective
386.12 applicant must apply to the commissioner for a new license.

386.13 Sec. 36. **[144H.05] FEES.**

386.14 Subdivision 1. **Initial application fee.** The initial application fee for PPEC center
386.15 licensure is \$11,000.

386.16 Subd. 2. **License renewal.** The fee for renewal of a PPEC center license is \$4,720.

386.17 Subd. 3. **Late fee.** The fee for late submission of an application to renew a PPEC center
386.18 license is \$25.

386.19 Subd. 4. **Nonrefundable; state government special revenue fund.** All fees collected
386.20 under this chapter are nonrefundable and must be deposited in the state treasury and credited
386.21 to the state government special revenue fund.

386.22 Sec. 37. **[144H.06] RULEMAKING.**

386.23 The commissioner shall adopt rules necessary to implement the technical implementation
386.24 for sections 144H.01, 144H.02, 144H.03, 144H.04, and 144H.05. Rules adopted under this
386.25 section shall include requirements for:

386.26 (1) applying for, issuing, and renewing PPEC center licenses;

386.27 (2) a center's physical plant, including standards for plumbing, electrical, ventilation,
386.28 heating and cooling, adequate space, accessibility, and fire protection. These standards must
386.29 be based on the size of the building and the number of children to be served in the building;
386.30 and

387.1 (3) limits to fines imposed by the commissioner for violations of this chapter or rules
387.2 adopted under this chapter.

387.3 **Sec. 38. [144H.07] SERVICES; LIMITATIONS.**

387.4 Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex
387.5 or technologically dependent children, based on a protocol of care established for each child.
387.6 A PPEC center may provide services up to 24 hours a day and up to seven days a week.

387.7 Subd. 2. **Limitations.** A PPEC center must comply with the following standards related
387.8 to services:

387.9 (1) a child is prohibited from attending a PPEC center for more than 14 hours within a
387.10 24-hour period;

387.11 (2) a PPEC center is prohibited from providing services other than those provided to
387.12 medically complex or technologically dependent children; and

387.13 (3) the maximum capacity for medically complex or technologically dependent children
387.14 at a center shall not exceed 45 children.

387.15 **Sec. 39. [144H.08] ADMINISTRATION AND MANAGEMENT.**

387.16 Subdivision 1. **Duties of owner.** (a) The owner of a PPEC center shall have full legal
387.17 authority and responsibility for the operation of the center. A PPEC center must be organized
387.18 according to a written table of organization, describing the lines of authority and
387.19 communication to the child care level. The organizational structure must be designed to
387.20 ensure an integrated continuum of services for the children served.

387.21 (b) The owner must designate one person as a center administrator, who is responsible
387.22 and accountable for overall management of the center.

387.23 Subd. 2. **Duties of administrator.** The center administrator is responsible and accountable
387.24 for overall management of the center. The administrator must:

387.25 (1) designate in writing a person to be responsible for the center when the administrator
387.26 is absent from the center for more than 24 hours;

387.27 (2) maintain the following written records, in a place and form and using a system that
387.28 allows for inspection of the records by the commissioner during normal business hours:

387.29 (i) a daily census record, which indicates the number of children currently receiving
387.30 services at the center;

388.1 (ii) a record of all accidents or unusual incidents involving any child or staff member
388.2 that caused, or had the potential to cause, injury or harm to a person at the center or to center
388.3 property;

388.4 (iii) copies of all current agreements with providers of supportive services or contracted
388.5 services;

388.6 (iv) copies of all current agreements with consultants employed by the center,
388.7 documentation of each consultant's visits, and written, dated reports; and

388.8 (v) a personnel record for each employee, which must include an application for
388.9 employment, references, employment history for the preceding five years, and copies of all
388.10 performance evaluations;

388.11 (3) develop and maintain a current job description for each employee;

388.12 (4) provide necessary qualified personnel and ancillary services to ensure the health,
388.13 safety, and proper care for each child; and

388.14 (5) develop and implement infection control policies that comply with rules adopted by
388.15 the commissioner regarding infection control.

388.16 Sec. 40. **[144H.09] ADMISSION, TRANSFER, AND DISCHARGE POLICIES;**
388.17 **CONSENT FORM.**

388.18 Subdivision 1. **Written policies.** A PPEC center must have written policies and
388.19 procedures governing the admission, transfer, and discharge of children.

388.20 Subd. 2. **Consent form.** A parent or guardian must sign a consent form outlining the
388.21 purpose of a PPEC center, specifying family responsibilities, authorizing treatment and
388.22 services, providing appropriate liability releases, and specifying emergency disposition
388.23 plans, before the child's admission to the center. The center must provide the child's parents
388.24 or guardians with a copy of the consent form and must maintain the consent form in the
388.25 child's medical record.

388.26 Sec. 41. **[144H.10] MEDICAL DIRECTOR.**

388.27 A PPEC center must have a medical director who is a physician licensed in Minnesota
388.28 and certified by the American Board of Pediatrics.

389.1 Sec. 42. **[144H.11] NURSING SERVICES.**

389.2 **Subdivision 1. Nursing director.** A PPEC center must have a nursing director who is
389.3 a registered nurse licensed in Minnesota, holds a current certification in cardiopulmonary
389.4 resuscitation, and has at least four years of general pediatric nursing experience, at least
389.5 one year of which must have been spent caring for medically fragile infants or children in
389.6 a pediatric intensive care, neonatal intensive care, PPEC center, or home care setting during
389.7 the previous five years. The nursing director is responsible for the daily operation of the
389.8 PPEC center.

389.9 **Subd. 2. Registered nurses.** A registered nurse employed by a PPEC center must be a
389.10 registered nurse licensed in Minnesota, hold a current certification in cardiopulmonary
389.11 resuscitation, and have experience in the previous 24 months in being responsible for the
389.12 care of acutely ill or chronically ill children.

389.13 **Subd. 3. Licensed practical nurses.** A licensed practical nurse employed by a PPEC
389.14 center must be supervised by a registered nurse and must be a licensed practical nurse
389.15 licensed in Minnesota, have at least two years of experience in pediatrics, and hold a current
389.16 certification in cardiopulmonary resuscitation.

389.17 **Subd. 4. Other direct care personnel.** (a) Direct care personnel governed by this
389.18 subdivision include nursing assistants and individuals with training and experience in the
389.19 field of education, social services, or child care.

389.20 (b) All direct care personnel employed by a PPEC center must work under the supervision
389.21 of a registered nurse and are responsible for providing direct care to children at the center.
389.22 Direct care personnel must have extensive, documented education and skills training in
389.23 providing care to infants and toddlers, provide employment references documenting skill
389.24 in the care of infants and children, and hold a current certification in cardiopulmonary
389.25 resuscitation.

389.26 Sec. 43. **[144H.12] TOTAL STAFFING FOR NURSING SERVICES AND DIRECT**
389.27 **CARE PERSONNEL.**

389.28 A PPEC center must provide total staffing for nursing services and direct care personnel
389.29 at a ratio of one staff person for every three children at the center. The staffing ratio required
389.30 in this section is the minimum staffing permitted.

390.1 Sec. 44. **[144H.13] MEDICAL RECORD; PROTOCOL OF CARE.**

390.2 A medical record and an individualized nursing protocol of care must be developed for
390.3 each child admitted to a PPEC center, must be maintained for each child, and must be signed
390.4 by authorized personnel.

390.5 Sec. 45. **[144H.14] QUALITY ASSURANCE PROGRAM.**

390.6 A PPEC center must have a quality assurance program, in which quarterly reviews are
390.7 conducted of the PPEC center's medical records and protocols of care for at least half of
390.8 the children served by the PPEC center. The quarterly review sample must be randomly
390.9 selected so each child at the center has an equal opportunity to be included in the review.
390.10 The committee conducting quality assurance reviews must include the medical director,
390.11 administrator, nursing director, and three other committee members determined by the PPEC
390.12 center.

390.13 Sec. 46. **[144H.15] INSPECTIONS.**

390.14 (a) The commissioner may inspect a PPEC center, including records held at the center,
390.15 at reasonable times as necessary to ensure compliance with this chapter and the rules adopted
390.16 under this chapter. During an inspection, a center must provide the commissioner with
390.17 access to all center records.

390.18 (b) The commissioner must inspect a PPEC center before issuing or renewing a license
390.19 under this chapter.

390.20 Sec. 47. **[144H.16] COMPLIANCE WITH OTHER LAWS.**

390.21 Subdivision 1. **Reporting of maltreatment of minors.** A PPEC center must develop
390.22 policies and procedures for reporting suspected child maltreatment that fulfill the
390.23 requirements of section 626.556. The policies and procedures must include the telephone
390.24 numbers of the local county child protection agency for reporting suspected maltreatment.
390.25 The policies and procedures specified in this subdivision must be provided to the parents
390.26 or guardians of all children at the time of admission to the PPEC center and must be available
390.27 upon request.

390.28 Subd. 2. **Crib safety requirements.** A PPEC center must comply with the crib safety
390.29 requirements in section 245A.146, to the extent they are applicable.

391.1 Sec. 48. **[144H.17] DENIAL, SUSPENSION, REVOCATION, REFUSAL TO RENEW**
391.2 **A LICENSE.**

391.3 (a) The commissioner may deny, suspend, revoke, or refuse to renew a license issued
391.4 under this chapter for:

391.5 (1) a violation of this chapter or rules adopted under this chapter; or

391.6 (2) an intentional or negligent act by an employee or contractor at the center that
391.7 materially affects the health or safety of children at the PPEC center.

391.8 (b) Prior to any suspension, revocation, or refusal to renew a license, a licensee shall be
391.9 entitled to a hearing and review as provided in sections 14.57 to 14.69.

391.10 Sec. 49. **[144H.18] FINES; CORRECTIVE ACTION PLANS.**

391.11 Subdivision 1. **Corrective action plans.** If the commissioner determines that a PPEC
391.12 center is not in compliance with this chapter or rules adopted under this chapter, the
391.13 commissioner may require the center to submit a corrective action plan that demonstrates
391.14 a good-faith effort to remedy each violation by a specific date, subject to approval by the
391.15 commissioner.

391.16 Subd. 2. **Fines.** The commissioner may issue a fine to a PPEC center, employee, or
391.17 contractor if the commissioner determines the center, employee, or contractor violated this
391.18 chapter or rules adopted under this chapter. The fine amount shall not exceed an amount
391.19 for each violation and an aggregate amount established by the commissioner in rule. The
391.20 failure to correct a violation by the date set by the commissioner, or a failure to comply
391.21 with an approved corrective action plan, constitutes a separate violation for each day the
391.22 failure continues, unless the commissioner approves an extension to a specific date. In
391.23 determining if a fine is to be imposed and establishing the amount of the fine, the
391.24 commissioner shall consider:

391.25 (1) the gravity of the violation, including the probability that death or serious physical
391.26 or emotional harm to a child will result or has resulted, the severity of the actual or potential
391.27 harm, and the extent to which the applicable laws were violated;

391.28 (2) actions taken by the owner or administrator to correct violations;

391.29 (3) any previous violations; and

391.30 (4) the financial benefit to the PPEC center of committing or continuing the violation.

392.1 Sec. 50. [144H.19] CLOSING A PPEC CENTER.

392.2 When a PPEC center voluntarily closes, it must, at least 30 days before closure, inform
392.3 each child's parents or guardians of the closure and when the closure will occur.

392.4 Sec. 51. Minnesota Statutes 2016, section 145.4716, subdivision 2, is amended to read:

392.5 Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible
392.6 for the following:

392.7 (1) developing and providing comprehensive training on sexual exploitation of youth
392.8 for social service professionals, medical professionals, public health workers, and criminal
392.9 justice professionals;

392.10 (2) collecting, organizing, maintaining, and disseminating information on sexual
392.11 exploitation and services across the state, including maintaining a list of resources on the
392.12 Department of Health Web site;

392.13 (3) monitoring and applying for federal funding for antitrafficking efforts that may
392.14 benefit victims in the state;

392.15 (4) managing grant programs established under sections 145.4716 to 145.4718, ~~and~~;
392.16 609.3241, paragraph (c), clause (3); and 609.5315, subdivision 5c, clause (3);

392.17 (5) managing the request for proposals for grants for comprehensive services, including
392.18 trauma-informed, culturally specific services;

392.19 (6) identifying best practices in serving sexually exploited youth, as defined in section
392.20 260C.007, subdivision 31;

392.21 (7) providing oversight of and technical support to regional navigators pursuant to section
392.22 145.4717;

392.23 (8) conducting a comprehensive evaluation of the statewide program for safe harbor of
392.24 sexually exploited youth; and

392.25 (9) developing a policy consistent with the requirements of chapter 13 for sharing data
392.26 related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among
392.27 regional navigators and community-based advocates.

393.1 Sec. 52. [145.9263] OPIOID PRESCRIBER EDUCATION AND PUBLIC
393.2 AWARENESS GRANTS.

393.3 The commissioner of health, in coordination with the commissioner of human services,
393.4 shall award grants to nonprofit organizations for the purpose of expanding prescriber
393.5 education, public awareness and outreach on the opioid epidemic and overdose prevention
393.6 programs. The grantees must coordinate with health care systems, professional associations,
393.7 and emergency medical services providers. Each grantee receiving funds under this section
393.8 shall report to the commissioner on how the funds were spent and the outcomes achieved.

393.9 Sec. 53. Minnesota Statutes 2016, section 145.986, subdivision 1a, is amended to read:

393.10 Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner
393.11 of health shall award competitive grants to community health boards and tribal governments
393.12 to convene, coordinate, and implement evidence-based strategies targeted at reducing the
393.13 percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.
393.14 Grants shall be awarded to all community health boards and tribal governments whose
393.15 proposals demonstrate the ability to implement programs designed to achieve the purposes
393.16 in subdivision 1 and other requirements of this section.

393.17 (b) Grantee activities shall:

393.18 (1) be based on scientific evidence;

393.19 (2) be based on community input;

393.20 (3) address behavior change at the individual, community, and systems levels;

393.21 (4) occur in community, school, work site, and health care settings;

393.22 (5) be focused on policy, systems, and environmental changes that support healthy
393.23 behaviors; and

393.24 (6) address the health disparities and inequities that exist in the grantee's community.

393.25 (c) To receive a grant under this section, community health boards and tribal governments
393.26 must submit proposals to the commissioner. A local match of ten percent of the total funding
393.27 allocation is required. This local match may include funds donated by community partners.

393.28 (d) In order to receive a grant, community health boards and tribal governments must
393.29 submit a health improvement plan to the commissioner of health for approval. The
393.30 commissioner may require the plan to identify a community leadership team, community
393.31 partners, and a community action plan that includes an assessment of area strengths and
393.32 needs, proposed action strategies, technical assistance needs, and a staffing plan.

394.1 (e) The grant recipient must implement the health improvement plan, evaluate the
394.2 effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

394.3 (f) Grant recipients shall report their activities and their progress toward the outcomes
394.4 established under subdivision 2 to the commissioner in a format and at a time specified by
394.5 the commissioner.

394.6 (g) All grant recipients shall be held accountable for making progress toward the
394.7 measurable outcomes established in subdivision 2. The commissioner shall require a
394.8 corrective action plan and may reduce the funding level of grant recipients that do not make
394.9 adequate progress toward the measurable outcomes.

394.10 (h) Beginning November 1, 2015, the commissioner shall offer grant recipients the
394.11 option of using a grant awarded under this subdivision to implement health improvement
394.12 strategies that improve the health status, delay the expression of dementia, or slow the
394.13 progression of dementia, for a targeted population at risk for dementia and shall award at
394.14 least two of the grants awarded on November 1, 2015, for these purposes. The grants must
394.15 meet all other requirements of this section. The commissioner shall coordinate grant planning
394.16 activities with the commissioner of human services, the Minnesota Board on Aging, and
394.17 community-based organizations with a focus on dementia. Each grant must include selected
394.18 outcomes and evaluation measures related to the incidence or progression of dementia
394.19 among the targeted population using the procedure described in subdivision 2.

394.20 (i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of
394.21 using a grant awarded under this subdivision to confront the opioid addiction and overdose
394.22 epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for
394.23 these purposes. The grants awarded under this paragraph must meet all other requirements
394.24 of this section. The commissioner shall coordinate grant planning activities with the
394.25 commissioner of human services. Each grant shall include selected outcomes and evaluation
394.26 measures related to addressing the opioid epidemic.

394.27 Sec. 54. Minnesota Statutes 2016, section 146B.02, subdivision 2, is amended to read:

394.28 Subd. 2. **Requirements and term of license.** (a) Each application for an initial mobile
394.29 or fixed-site establishment license and for renewal must be submitted to the commissioner
394.30 on a form provided by the commissioner accompanied with the applicable fee required
394.31 under section 146B.10. The application must contain:

394.32 (1) the name(s) of the owner(s) and operator(s) of the establishment;

394.33 (2) the location of the establishment;

395.1 (3) verification of compliance with all applicable local and state codes;

395.2 (4) a description of the general nature of the business; and

395.3 (5) any other relevant information deemed necessary by the commissioner.

395.4 (b) If the information submitted is complete and complies with the requirements of this
395.5 chapter, the commissioner shall issue a provisional establishment license. The provisional
395.6 license is effective until the commissioner determines, after inspection, that the applicant
395.7 has met the requirements of this chapter. Upon approval, the commissioner shall issue a
395.8 body art establishment license effective for three years.

395.9 (c) An establishment license must be renewed every two years.

395.10 Sec. 55. Minnesota Statutes 2016, section 146B.02, subdivision 5, is amended to read:

395.11 Subd. 5. **Transfer of ownership, relocation, and display of license.** (a) A body art
395.12 establishment license must be issued to a specific person and location and is not transferable.
395.13 A license must be prominently displayed in a public area of the establishment.

395.14 (b) An owner who has purchased a body art establishment licensed under the previous
395.15 owner must submit an application to license the establishment within two weeks of the date
395.16 of sale. Notwithstanding subdivision 1, the new owner may continue to operate for 60 days
395.17 after the sale while waiting for a new license to be issued.

395.18 (c) An owner of a licensed body art establishment who is relocating the establishment
395.19 must submit an application for the new location. The owner may request that the new
395.20 application become effective at a specified date in the future. If the relocation is not
395.21 accomplished by the date expected, and the license at the existing location expires, the
395.22 owner may apply for a temporary event permit to continue to operate at the old location.
395.23 The owner may apply for no more than four temporary event permits to continue operating
395.24 at the old location.

395.25 Sec. 56. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision
395.26 to read:

395.27 Subd. 7a. **Supervisors.** (a) Only a technician who has been licensed as a body artist for
395.28 at least two years in Minnesota or in a jurisdiction with which Minnesota has reciprocity
395.29 may supervise a temporary technician.

395.30 (b) Any technician who agrees to supervise more than two temporary technicians during
395.31 the same time period must explain, to the satisfaction of the commissioner, how the technician

396.1 will provide supervision to each temporary technician in accordance with section 146B.01,
 396.2 subdivision 28.

396.3 (c) The commissioner may refuse to approve as a supervisor a technician who has been
 396.4 disciplined in Minnesota or in another jurisdiction.

396.5 Sec. 57. Minnesota Statutes 2016, section 146B.02, subdivision 8, is amended to read:

396.6 Subd. 8. **Temporary events event permit.** (a) ~~An owner or operator of a~~ applicant for
 396.7 a permit to hold a temporary body art establishment event shall submit an application ~~for a~~
 396.8 ~~temporary events permit~~ to the commissioner. The application must be received at least 14
 396.9 days before the start of the event. The application must include the specific days and hours
 396.10 of operation. ~~The owner or operator~~ An applicant issued a temporary event permit shall
 396.11 comply with the requirements of this chapter.

396.12 (b) Applications received less than 14 days prior to the start of the event may be processed
 396.13 if the commissioner determines it is possible to conduct ~~the~~ all required work, including an
 396.14 inspection.

396.15 (c) The temporary ~~events~~ event permit must be prominently displayed in a public area
 396.16 at the location.

396.17 (d) The temporary ~~events~~ event permit, if approved, is valid for the specified dates and
 396.18 hours listed on the application. No temporary events permit shall be issued for longer than
 396.19 a 21-day period, and may not be extended.

396.20 (e) No individual who does not hold a current body art establishment license may be
 396.21 issued a temporary event permit more than four times within the same calendar year.

396.22 (f) No individual who has been disciplined for a serious violation of this chapter within
 396.23 three years preceding the intended start date of a temporary event may be issued a license
 396.24 for a temporary event. Violations that preclude issuance of a temporary event permit include
 396.25 unlicensed practice; practice in an unlicensed location; any of the conditions listed in section
 396.26 146B.05, clauses (1) to (8), (12), or (13), 146B.08, subdivision 3, clauses (4), (5), and (10)
 396.27 to (12), or any other violation that places the health or safety of a client at risk.

396.28 Sec. 58. Minnesota Statutes 2016, section 146B.02, is amended by adding a subdivision
 396.29 to read:

396.30 Subd. 10. **Licensure precluded.** (a) The commissioner may choose to deny a body art
 396.31 establishment license to an applicant who has been disciplined for a serious violation under
 396.32 this chapter. Violations that constitute grounds for denial of license are any of the conditions

397.1 listed in section 146B.05, subdivision 1, clauses (1) to (8), (12), or (13), 146B.08, subdivision
397.2 3, clauses (4), (5), or (10) to (12), or any other violation that places the health or safety of
397.3 a client at risk.

397.4 (b) In considering whether to grant a license to an applicant who has been disciplined
397.5 for a violation described in this subdivision, the commissioner shall consider evidence of
397.6 rehabilitation, including the nature and seriousness of the violation, circumstances relative
397.7 to the violation, the length of time elapsed since the violation, and evidence that demonstrates
397.8 that the applicant has maintained safe, ethical, and responsible body art practice since the
397.9 time of the most recent violation.

397.10 Sec. 59. Minnesota Statutes 2016, section 146B.03, subdivision 6, is amended to read:

397.11 Subd. 6. **Licensure term; renewal.** (a) A technician's license is valid for two years from
397.12 the date of issuance and may be renewed upon payment of the renewal fee established under
397.13 section 146B.10.

397.14 (b) At renewal, a licensee must submit proof of continuing education approved by the
397.15 commissioner in the areas identified in subdivision 4.

397.16 (c) The commissioner shall notify the technician of the pending expiration of a technician
397.17 license at least 60 days prior to license expiration.

397.18 (d) A technician previously licensed in Minnesota whose license has lapsed for less than
397.19 six years may apply to renew. A technician previously licensed in Minnesota whose license
397.20 has lapsed for less than ten years and who was licensed in another jurisdiction or jurisdictions
397.21 during the entire time of lapse may apply to renew, but must submit proof of licensure in
397.22 good standing in all other jurisdictions in which the technician was licensed as a body artist
397.23 during the time of lapse. A technician previously licensed in Minnesota whose license has
397.24 lapsed for more than six years and who was not continuously licensed in another jurisdiction
397.25 during the period of Minnesota lapse must reapply for licensure under subdivision 4.

397.26 Sec. 60. Minnesota Statutes 2016, section 146B.03, subdivision 7, is amended to read:

397.27 Subd. 7. **Temporary licensure.** (a) The commissioner may issue a temporary license
397.28 to an applicant who submits to the commissioner on a form provided by the commissioner:

397.29 (1) proof that the applicant is over the age of 18;

397.30 (2) all fees required under section 148B.10; and

398.1 (3) a letter from a licensed technician who has agreed to provide the supervision to meet
398.2 the supervised experience requirement under subdivision 4.

398.3 (b) Upon completion of the required supervised experience, the temporary licensee shall
398.4 submit documentation of satisfactorily completing the requirements under subdivision 4,
398.5 and the applicable fee under section 146B.10. The commissioner shall issue a new license
398.6 in accordance with subdivision 4.

398.7 (c) A temporary license issued under this subdivision is valid for one year and may be
398.8 renewed ~~for one additional year~~ twice.

398.9 Sec. 61. Minnesota Statutes 2016, section 146B.07, subdivision 4, is amended to read:

398.10 Subd. 4. **Client record maintenance.** (a) For each client, the body art establishment
398.11 operator shall maintain proper records of each procedure. The records of the procedure must
398.12 be kept for three years and must be available for inspection by the commissioner upon
398.13 request. The record must include the following:

398.14 (1) the date of the procedure;

398.15 (2) the information on the required picture identification showing the name, age, and
398.16 current address of the client;

398.17 (3) a copy of the authorization form signed and dated by the client required under
398.18 subdivision 1, paragraph (b);

398.19 (4) a description of the body art procedure performed;

398.20 (5) the name and license number of the technician performing the procedure;

398.21 (6) a copy of the consent form required under subdivision 3; and

398.22 (7) if the client is under the age of 18 years, a copy of the consent form signed by the
398.23 parent or legal guardian as required under subdivision 2.

398.24 (b) Each body artist shall maintain a copy of the informed consent required under
398.25 subdivision 3 for three years.

398.26 Sec. 62. Minnesota Statutes 2016, section 146B.10, subdivision 1, is amended to read:

398.27 Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure and biennial
398.28 licensure renewal is \$100.

398.29 (b) The fee for temporary technician licensure is \$100.

398.30 (c) The fee for the temporary guest artist license is \$50.

399.1 (d) The fee for a dual body art technician license is \$100.

399.2 (e) The fee for a provisional establishment license is \$1,000.

399.3 (f) The fee for an initial establishment license and the three-year license renewal period
399.4 required in section 146B.02, subdivision 2, paragraph (b), is \$1,000.

399.5 (g) The fee for a temporary body art establishment permit is \$75.

399.6 (h) The commissioner shall prorate the initial two-year technician license fee and the
399.7 initial three-year body art establishment license fee based on the number of months in the
399.8 initial licensure period. The commissioner shall prorate the first renewal fee for the
399.9 establishment license based on the number of months from issuance of the provisional
399.10 license to the first renewal.

399.11 Sec. 63. Minnesota Statutes 2016, section 148.5194, subdivision 7, is amended to read:

399.12 Subd. 7. **Audiologist biennial licensure fee.** ~~(a) The licensure fee for initial applicants~~
399.13 ~~is \$435.~~ The biennial licensure fee for audiologists for clinical fellowship, doctoral externship,
399.14 temporary, ~~initial applicants,~~ and renewal ~~licensees~~ licenses is \$435.

399.15 ~~(b) The audiologist fee is for practical examination costs greater than audiologist exam~~
399.16 ~~fee receipts and for complaint investigation, enforcement action, and consumer information~~
399.17 ~~and assistance expenditures related to hearing instrument dispensing.~~

399.18 Sec. 64. Minnesota Statutes 2016, section 157.16, subdivision 1, is amended to read:

399.19 Subdivision 1. **License required annually.** A license is required annually for every
399.20 person, firm, or corporation engaged in the business of conducting a food and beverage
399.21 service establishment, youth camp, hotel, motel, lodging establishment, public pool, or
399.22 resort. Any person wishing to operate a place of business licensed in this section shall first
399.23 make application, pay the required fee specified in this section, and receive approval for
399.24 operation, including plan review approval. Special event food stands are not required to
399.25 submit plans. Nonprofit organizations operating a special event food stand with multiple
399.26 locations at an annual one-day event shall be issued only one license. Application shall be
399.27 made on forms provided by the commissioner and shall require the applicant to state the
399.28 full name and address of the owner of the building, structure, or enclosure, the lessee and
399.29 manager of the food and beverage service establishment, hotel, motel, lodging establishment,
399.30 public pool, or resort; the name under which the business is to be conducted; and any other
399.31 information as may be required by the commissioner to complete the application for license.

400.1 All fees collected under this section shall be deposited in the state government special
400.2 revenue fund.

400.3 Sec. 65. Minnesota Statutes 2016, section 327.15, subdivision 3, is amended to read:

400.4 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The
400.5 following fees are required for manufactured home parks and recreational camping areas
400.6 licensed under this chapter. Fees collected under this section shall be deposited in the state
400.7 government special revenue fund. Recreational camping areas and manufactured home
400.8 parks shall pay the highest applicable base fee under paragraph (b). The license fee for new
400.9 operators of a manufactured home park or recreational camping area previously licensed
400.10 under this chapter for the same calendar year is one-half of the appropriate annual license
400.11 fee, plus any penalty that may be required. The license fee for operators opening on or after
400.12 October 1 is one-half of the appropriate annual license fee, plus any penalty that may be
400.13 required.

400.14 (b) All manufactured home parks and recreational camping areas shall pay the following
400.15 annual base fee:

400.16 (1) a manufactured home park, \$150; and

400.17 (2) a recreational camping area with:

400.18 (i) 24 or less sites, \$50;

400.19 (ii) 25 to 99 sites, \$212; and

400.20 (iii) 100 or more sites, \$300.

400.21 In addition to the base fee, manufactured home parks and recreational camping areas shall
400.22 pay \$4 for each licensed site. This paragraph does not apply to special event recreational
400.23 camping areas. Operators of a manufactured home park or a recreational camping area also
400.24 licensed under section 157.16 for the same location shall pay only one base fee, whichever
400.25 is the highest of the base fees found in this section or section 157.16.

400.26 (c) In addition to the fee in paragraph (b), each manufactured home park or recreational
400.27 camping area shall pay an additional annual fee for each fee category specified in this
400.28 paragraph:

400.29 (1) Manufactured home parks and recreational camping areas with public swimming
400.30 pools and spas shall pay the appropriate fees specified in section 157.16.

400.31 (2) Individual private sewer or water, \$60. "Individual private water" means a fee category
400.32 with a water supply other than a community public water supply as defined in Minnesota

401.1 Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface
401.2 sewage treatment system which uses subsurface treatment and disposal.

401.3 (d) The following fees must accompany a plan review application for initial construction
401.4 of a manufactured home park or recreational camping area:

401.5 (1) for initial construction of less than 25 sites, \$375;

401.6 (2) for initial construction of 25 to 99 sites, \$400; and

401.7 (3) for initial construction of 100 or more sites, \$500.

401.8 (e) The following fees must accompany a plan review application when an existing
401.9 manufactured home park or recreational camping area is expanded:

401.10 (1) for expansion of less than 25 sites, \$250;

401.11 (2) for expansion of 25 to 99 sites, \$300; and

401.12 (3) for expansion of 100 or more sites, \$450.

401.13 Sec. 66. Minnesota Statutes 2016, section 609.5315, subdivision 5c, is amended to read:

401.14 Subd. 5c. **Disposition of money; prostitution.** Money forfeited under section 609.5312,
401.15 subdivision 1, paragraph (b), must be distributed as follows:

401.16 (1) 40 percent must be forwarded to the appropriate agency for deposit as a supplement
401.17 to the agency's operating fund or similar fund for use in law enforcement;

401.18 (2) 20 percent must be forwarded to the prosecuting authority that handled the forfeiture
401.19 for deposit as a supplement to its operating fund or similar fund for prosecutorial purposes;
401.20 and

401.21 (3) the remaining 40 percent must be forwarded to the commissioner of ~~public safety~~
401.22 health to be deposited in the safe harbor for youth account in the special revenue fund and
401.23 is appropriated to the commissioner for distribution to crime victims services organizations
401.24 that provide services to sexually exploited youth, as defined in section 260C.007, subdivision
401.25 31.

401.26 Sec. 67. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

401.27 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
401.28 given them unless the specific content indicates otherwise:

401.29 (a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence
401.30 or event which:

402.1 (1) is not likely to occur and could not have been prevented by exercise of due care; and

402.2 (2) if occurring while a child is receiving services from a facility, happens when the
402.3 facility and the employee or person providing services in the facility are in compliance with
402.4 the laws and rules relevant to the occurrence or event.

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

402.6 (c) "Facility" means:

402.7 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
402.8 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
402.9 144.58, 241.021, or 245A.01 to 245A.16, or chapter 144H or 245D;

402.10 (2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E;
402.11 or

402.12 (3) a nonlicensed personal care provider organization as defined in section 256B.0625,
402.13 subdivision 19a.

402.14 (d) "Family assessment" means a comprehensive assessment of child safety, risk of
402.15 subsequent child maltreatment, and family strengths and needs that is applied to a child
402.16 maltreatment report that does not allege sexual abuse or substantial child endangerment.
402.17 Family assessment does not include a determination as to whether child maltreatment
402.18 occurred but does determine the need for services to address the safety of family members
402.19 and the risk of subsequent maltreatment.

402.20 (e) "Investigation" means fact gathering related to the current safety of a child and the
402.21 risk of subsequent maltreatment that determines whether child maltreatment occurred and
402.22 whether child protective services are needed. An investigation must be used when reports
402.23 involve sexual abuse or substantial child endangerment, and for reports of maltreatment in
402.24 facilities required to be licensed under chapter 245A or 245D; under sections 144.50 to
402.25 144.58 and 241.021; in a school as defined in section 120A.05, subdivisions 9, 11, and 13,
402.26 and chapter 124E; or in a nonlicensed personal care provider association as defined in section
402.27 256B.0625, subdivision 19a.

402.28 (f) "Mental injury" means an injury to the psychological capacity or emotional stability
402.29 of a child as evidenced by an observable or substantial impairment in the child's ability to
402.30 function within a normal range of performance and behavior with due regard to the child's
402.31 culture.

402.32 (g) "Neglect" means the commission or omission of any of the acts specified under
402.33 clauses (1) to (9), other than by accidental means:

403.1 (1) failure by a person responsible for a child's care to supply a child with necessary
403.2 food, clothing, shelter, health, medical, or other care required for the child's physical or
403.3 mental health when reasonably able to do so;

403.4 (2) failure to protect a child from conditions or actions that seriously endanger the child's
403.5 physical or mental health when reasonably able to do so, including a growth delay, which
403.6 may be referred to as a failure to thrive, that has been diagnosed by a physician and is due
403.7 to parental neglect;

403.8 (3) failure to provide for necessary supervision or child care arrangements appropriate
403.9 for a child after considering factors as the child's age, mental ability, physical condition,
403.10 length of absence, or environment, when the child is unable to care for the child's own basic
403.11 needs or safety, or the basic needs or safety of another child in their care;

403.12 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
403.13 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
403.14 child with sympathomimetic medications, consistent with section 125A.091, subdivision
403.15 5;

403.16 (5) nothing in this section shall be construed to mean that a child is neglected solely
403.17 because the child's parent, guardian, or other person responsible for the child's care in good
403.18 faith selects and depends upon spiritual means or prayer for treatment or care of disease or
403.19 remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker,
403.20 or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of
403.21 medical care may cause serious danger to the child's health. This section does not impose
403.22 upon persons, not otherwise legally responsible for providing a child with necessary food,
403.23 clothing, shelter, education, or medical care, a duty to provide that care;

403.24 (6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision
403.25 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in
403.26 the child at birth, results of a toxicology test performed on the mother at delivery or the
403.27 child at birth, medical effects or developmental delays during the child's first year of life
403.28 that medically indicate prenatal exposure to a controlled substance, or the presence of a
403.29 fetal alcohol spectrum disorder;

403.30 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

403.31 (8) chronic and severe use of alcohol or a controlled substance by a parent or person
403.32 responsible for the care of the child that adversely affects the child's basic needs and safety;
403.33 or

404.1 (9) emotional harm from a pattern of behavior which contributes to impaired emotional
404.2 functioning of the child which may be demonstrated by a substantial and observable effect
404.3 in the child's behavior, emotional response, or cognition that is not within the normal range
404.4 for the child's age and stage of development, with due regard to the child's culture.

404.5 (h) "Nonmaltreatment mistake" means:

404.6 (1) at the time of the incident, the individual was performing duties identified in the
404.7 center's child care program plan required under Minnesota Rules, part 9503.0045;

404.8 (2) the individual has not been determined responsible for a similar incident that resulted
404.9 in a finding of maltreatment for at least seven years;

404.10 (3) the individual has not been determined to have committed a similar nonmaltreatment
404.11 mistake under this paragraph for at least four years;

404.12 (4) any injury to a child resulting from the incident, if treated, is treated only with
404.13 remedies that are available over the counter, whether ordered by a medical professional or
404.14 not; and

404.15 (5) except for the period when the incident occurred, the facility and the individual
404.16 providing services were both in compliance with all licensing requirements relevant to the
404.17 incident.

404.18 This definition only applies to child care centers licensed under Minnesota Rules, chapter
404.19 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated
404.20 maltreatment by the individual, the commissioner of human services shall determine that a
404.21 nonmaltreatment mistake was made by the individual.

404.22 (i) "Operator" means an operator or agency as defined in section 245A.02.

404.23 (j) "Person responsible for the child's care" means (1) an individual functioning within
404.24 the family unit and having responsibilities for the care of the child such as a parent, guardian,
404.25 or other person having similar care responsibilities, or (2) an individual functioning outside
404.26 the family unit and having responsibilities for the care of the child such as a teacher, school
404.27 administrator, other school employees or agents, or other lawful custodian of a child having
404.28 either full-time or short-term care responsibilities including, but not limited to, day care,
404.29 babysitting whether paid or unpaid, counseling, teaching, and coaching.

404.30 (k) "Physical abuse" means any physical injury, mental injury, or threatened injury,
404.31 inflicted by a person responsible for the child's care on a child other than by accidental
404.32 means, or any physical or mental injury that cannot reasonably be explained by the child's

405.1 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
405.2 that have not been authorized under section 125A.0942 or 245.825.

405.3 Abuse does not include reasonable and moderate physical discipline of a child
405.4 administered by a parent or legal guardian which does not result in an injury. Abuse does
405.5 not include the use of reasonable force by a teacher, principal, or school employee as allowed
405.6 by section 121A.582. Actions which are not reasonable and moderate include, but are not
405.7 limited to, any of the following:

405.8 (1) throwing, kicking, burning, biting, or cutting a child;

405.9 (2) striking a child with a closed fist;

405.10 (3) shaking a child under age three;

405.11 (4) striking or other actions which result in any nonaccidental injury to a child under 18
405.12 months of age;

405.13 (5) unreasonable interference with a child's breathing;

405.14 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

405.15 (7) striking a child under age one on the face or head;

405.16 (8) striking a child who is at least age one but under age four on the face or head, which
405.17 results in an injury;

405.18 (9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
405.19 substances which were not prescribed for the child by a practitioner, in order to control or
405.20 punish the child; or other substances that substantially affect the child's behavior, motor
405.21 coordination, or judgment or that results in sickness or internal injury, or subjects the child
405.22 to medical procedures that would be unnecessary if the child were not exposed to the
405.23 substances;

405.24 (10) unreasonable physical confinement or restraint not permitted under section 609.379,
405.25 including but not limited to tying, caging, or chaining; or

405.26 (11) in a school facility or school zone, an act by a person responsible for the child's
405.27 care that is a violation under section 121A.58.

405.28 (l) "Practice of social services," for the purposes of subdivision 3, includes but is not
405.29 limited to employee assistance counseling and the provision of guardian ad litem and
405.30 parenting time expeditor services.

406.1 (m) "Report" means any communication received by the local welfare agency, police
406.2 department, county sheriff, or agency responsible for child protection pursuant to this section
406.3 that describes neglect or physical or sexual abuse of a child and contains sufficient content
406.4 to identify the child and any person believed to be responsible for the neglect or abuse, if
406.5 known.

406.6 (n) "Sexual abuse" means the subjection of a child by a person responsible for the child's
406.7 care, by a person who has a significant relationship to the child, as defined in section 609.341,
406.8 or by a person in a position of authority, as defined in section 609.341, subdivision 10, to
406.9 any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first
406.10 degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual
406.11 conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or
406.12 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act
406.13 which involves a minor which constitutes a violation of prostitution offenses under sections
406.14 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports
406.15 of known or suspected child sex trafficking involving a child who is identified as a victim
406.16 of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321,
406.17 subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the
406.18 status of a parent or household member who has committed a violation which requires
406.19 registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or
406.20 required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

406.21 (o) "Substantial child endangerment" means a person responsible for a child's care, by
406.22 act or omission, commits or attempts to commit an act against a child under their care that
406.23 constitutes any of the following:

406.24 (1) egregious harm as defined in section 260C.007, subdivision 14;

406.25 (2) abandonment under section 260C.301, subdivision 2;

406.26 (3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's
406.27 physical or mental health, including a growth delay, which may be referred to as failure to
406.28 thrive, that has been diagnosed by a physician and is due to parental neglect;

406.29 (4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

406.30 (5) manslaughter in the first or second degree under section 609.20 or 609.205;

406.31 (6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

406.32 (7) solicitation, inducement, and promotion of prostitution under section 609.322;

406.33 (8) criminal sexual conduct under sections 609.342 to 609.3451;

407.1 (9) solicitation of children to engage in sexual conduct under section 609.352;

407.2 (10) malicious punishment or neglect or endangerment of a child under section 609.377
407.3 or 609.378;

407.4 (11) use of a minor in sexual performance under section 617.246; or

407.5 (12) parental behavior, status, or condition which mandates that the county attorney file
407.6 a termination of parental rights petition under section 260C.503, subdivision 2.

407.7 (p) "Threatened injury" means a statement, overt act, condition, or status that represents
407.8 a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes,
407.9 but is not limited to, exposing a child to a person responsible for the child's care, as defined
407.10 in paragraph (j), clause (1), who has:

407.11 (1) subjected a child to, or failed to protect a child from, an overt act or condition that
407.12 constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law
407.13 of another jurisdiction;

407.14 (2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph
407.15 (b), clause (4), or a similar law of another jurisdiction;

407.16 (3) committed an act that has resulted in an involuntary termination of parental rights
407.17 under section 260C.301, or a similar law of another jurisdiction; or

407.18 (4) committed an act that has resulted in the involuntary transfer of permanent legal and
407.19 physical custody of a child to a relative under Minnesota Statutes 2010, ~~section 260C.201,~~
407.20 ~~subdivision 11, paragraph (d), clause (1),~~ section 260C.515, subdivision 4, or a similar law
407.21 of another jurisdiction.

407.22 A child is the subject of a report of threatened injury when the responsible social services
407.23 agency receives birth match data under paragraph (q) from the Department of Human
407.24 Services.

407.25 (q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth
407.26 record or recognition of parentage identifying a child who is subject to threatened injury
407.27 under paragraph (p), the Department of Human Services shall send the data to the responsible
407.28 social services agency. The data is known as "birth match" data. Unless the responsible
407.29 social services agency has already begun an investigation or assessment of the report due
407.30 to the birth of the child or execution of the recognition of parentage and the parent's previous
407.31 history with child protection, the agency shall accept the birth match data as a report under
407.32 this section. The agency may use either a family assessment or investigation to determine
407.33 whether the child is safe. All of the provisions of this section apply. If the child is determined

408.1 to be safe, the agency shall consult with the county attorney to determine the appropriateness
408.2 of filing a petition alleging the child is in need of protection or services under section
408.3 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is
408.4 determined not to be safe, the agency and the county attorney shall take appropriate action
408.5 as required under section 260C.503, subdivision 2.

408.6 (r) Persons who conduct assessments or investigations under this section shall take into
408.7 account accepted child-rearing practices of the culture in which a child participates and
408.8 accepted teacher discipline practices, which are not injurious to the child's health, welfare,
408.9 and safety.

408.10 Sec. 68. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

408.11 Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person
408.12 who knows or has reason to believe a child is being neglected or physically or sexually
408.13 abused, as defined in subdivision 2, or has been neglected or physically or sexually abused
408.14 within the preceding three years, shall immediately report the information to the local welfare
408.15 agency, agency responsible for assessing or investigating the report, police department,
408.16 county sheriff, tribal social services agency, or tribal police department if the person is:

408.17 (1) a professional or professional's delegate who is engaged in the practice of the healing
408.18 arts, social services, hospital administration, psychological or psychiatric treatment, child
408.19 care, education, correctional supervision, probation and correctional services, or law
408.20 enforcement; or

408.21 (2) employed as a member of the clergy and received the information while engaged in
408.22 ministerial duties, provided that a member of the clergy is not required by this subdivision
408.23 to report information that is otherwise privileged under section 595.02, subdivision 1,
408.24 paragraph (c).

408.25 (b) Any person may voluntarily report to the local welfare agency, agency responsible
408.26 for assessing or investigating the report, police department, county sheriff, tribal social
408.27 services agency, or tribal police department if the person knows, has reason to believe, or
408.28 suspects a child is being or has been neglected or subjected to physical or sexual abuse.

408.29 (c) A person mandated to report physical or sexual child abuse or neglect occurring
408.30 within a licensed facility shall report the information to the agency responsible for licensing
408.31 the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 144H
408.32 or 245D; or a nonlicensed personal care provider organization as defined in section
408.33 256B.0625, subdivision ~~19~~ 19a. A health or corrections agency receiving a report may

409.1 request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and
409.2 10b. A board or other entity whose licensees perform work within a school facility, upon
409.3 receiving a complaint of alleged maltreatment, shall provide information about the
409.4 circumstances of the alleged maltreatment to the commissioner of education. Section 13.03,
409.5 subdivision 4, applies to data received by the commissioner of education from a licensing
409.6 entity.

409.7 (d) Notification requirements under subdivision 10 apply to all reports received under
409.8 this section.

409.9 (e) For purposes of this section, "immediately" means as soon as possible but in no event
409.10 longer than 24 hours.

409.11 Sec. 69. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

409.12 Subd. 3c. **Local welfare agency, Department of Human Services or Department of**
409.13 **Health responsible for assessing or investigating reports of maltreatment.** (a) The county
409.14 local welfare agency is the agency responsible for assessing or investigating allegations of
409.15 maltreatment in child foster care, family child care, legally unlicensed child care, juvenile
409.16 correctional facilities licensed under section 241.021 located in the local welfare agency's
409.17 county, and reports involving children served by an unlicensed personal care provider
409.18 organization under section 256B.0659. Copies of findings related to personal care provider
409.19 organizations under section 256B.0659 must be forwarded to the Department of Human
409.20 Services provider enrollment.

409.21 (b) The Department of Human Services is the agency responsible for assessing or
409.22 investigating allegations of maltreatment in facilities licensed under chapters 245A and
409.23 245D, except for child foster care and family child care.

409.24 (c) The Department of Health is the agency responsible for assessing or investigating
409.25 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
409.26 144A.43 to 144A.482 or chapter 144H.

409.27 Sec. 70. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

409.28 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received
409.29 that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the
409.30 care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
409.31 sanitarium, or other facility or institution required to be licensed according to sections 144.50
409.32 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 144H or 245D, or a school as defined

410.1 in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal
410.2 care provider organization as defined in section 256B.0625, subdivision 19a, the
410.3 commissioner of the agency responsible for assessing or investigating the report or local
410.4 welfare agency investigating the report shall provide the following information to the parent,
410.5 guardian, or legal custodian of a child alleged to have been neglected, physically abused,
410.6 sexually abused, or the victim of maltreatment of a child in the facility: the name of the
410.7 facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment
410.8 of a child in the facility has been received; the nature of the alleged neglect, physical abuse,
410.9 sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an
410.10 assessment or investigation; any protective or corrective measures being taken pending the
410.11 outcome of the investigation; and that a written memorandum will be provided when the
410.12 investigation is completed.

410.13 (b) The commissioner of the agency responsible for assessing or investigating the report
410.14 or local welfare agency may also provide the information in paragraph (a) to the parent,
410.15 guardian, or legal custodian of any other child in the facility if the investigative agency
410.16 knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or
410.17 maltreatment of a child in the facility has occurred. In determining whether to exercise this
410.18 authority, the commissioner of the agency responsible for assessing or investigating the
410.19 report or local welfare agency shall consider the seriousness of the alleged neglect, physical
410.20 abuse, sexual abuse, or maltreatment of a child in the facility; the number of children
410.21 allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a
410.22 child in the facility; the number of alleged perpetrators; and the length of the investigation.
410.23 The facility shall be notified whenever this discretion is exercised.

410.24 (c) When the commissioner of the agency responsible for assessing or investigating the
410.25 report or local welfare agency has completed its investigation, every parent, guardian, or
410.26 legal custodian previously notified of the investigation by the commissioner or local welfare
410.27 agency shall be provided with the following information in a written memorandum: the
410.28 name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual
410.29 abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the
410.30 investigation findings; a statement whether maltreatment was found; and the protective or
410.31 corrective measures that are being or will be taken. The memorandum shall be written in a
410.32 manner that protects the identity of the reporter and the child and shall not contain the name,
410.33 or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed
410.34 during the investigation. If maltreatment is determined to exist, the commissioner or local
410.35 welfare agency shall also provide the written memorandum to the parent, guardian, or legal

411.1 custodian of each child in the facility who had contact with the individual responsible for
411.2 the maltreatment. When the facility is the responsible party for maltreatment, the
411.3 commissioner or local welfare agency shall also provide the written memorandum to the
411.4 parent, guardian, or legal custodian of each child who received services in the population
411.5 of the facility where the maltreatment occurred. This notification must be provided to the
411.6 parent, guardian, or legal custodian of each child receiving services from the time the
411.7 maltreatment occurred until either the individual responsible for maltreatment is no longer
411.8 in contact with a child or children in the facility or the conclusion of the investigation. In
411.9 the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions
411.10 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification
411.11 to parents, guardians, or legal custodians of each child in the facility, but shall, within ten
411.12 days after the investigation is completed, provide written notification to the parent, guardian,
411.13 or legal custodian of any student alleged to have been maltreated. The commissioner of
411.14 education may notify the parent, guardian, or legal custodian of any student involved as a
411.15 witness to alleged maltreatment.

411.16 Sec. 71. Laws 2014, chapter 312, article 23, section 9, is amended by adding a subdivision
411.17 to read:

411.18 Subd. 5a. Report to legislature. (a) The Legislative Health Care Workforce Commission
411.19 must provide a preliminary report to the legislature by December 31, 2018. The report must
411.20 include the following:

411.21 (1) baseline data on the current supply and distribution of health care providers in the
411.22 state;

411.23 (2) current projections of the demand for health professionals;

411.24 (3) other data and analysis the commission is able to complete; and

411.25 (4) recommendations on actions needed.

411.26 (b) The commission must provide a final report to the legislature by December 31, 2020.
411.27 The final report must include a comprehensive five-year workforce plan that:

411.28 (1) identifies current and anticipated health care workforce shortages by both provider
411.29 type and geography;

411.30 (2) evaluates the effectiveness of incentives currently available to develop, attract, and
411.31 retain a highly skilled and diverse health care workforce;

412.1 (3) evaluates alternative incentives to develop, attract, and retain a highly skilled and
 412.2 diverse health care workforce;

412.3 (4) identifies current causes and potential solutions to barriers related to the primary
 412.4 care workforce including, but not limited to, training and residency shortages, disparities
 412.5 in income between primary care and other providers, and negative perceptions of primary
 412.6 care among students;

412.7 (5) assesses the current supply and distribution of health care providers in the state,
 412.8 trends in health care delivery, access, reform, and the effects of these trends on workforce
 412.9 needs;

412.10 (6) analyzes the effects of changing models of health care delivery, including team
 412.11 models of care and emerging professions, on the demand for health professionals;

412.12 (7) projects the five-year demand and supply of health professionals necessary to meet
 412.13 the needs of health care within the state;

412.14 (8) identifies all funding sources for which the state has administrative control that are
 412.15 available for health professions training;

412.16 (9) recommends how to improve data evaluation and analysis;

412.17 (10) recommends how to improve oral health, mental health, and primary care training
 412.18 and practice;

412.19 (11) recommends how to improve the long-term care workforce; and

412.20 (12) recommends actions needed to meet the projected demand for health professionals
 412.21 over the five years of the plan.

412.22 Sec. 72. Laws 2014, chapter 312, article 23, section 9, subdivision 8, is amended to read:

412.23 Subd. 8. **Expiration.** The Legislative Health Care Workforce Commission expires on
 412.24 January 1, ~~2017~~ 2021.

412.25 Sec. 73. Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended by Laws
 412.26 2015, First Special Session chapter 6, section 2, is amended to read:

412.27 Subd. 2. **Health Improvement**

Appropriations by Fund			
412.29	General	68,653,000	68,984,000
412.30	State Government		
412.31	Special Revenue	6,264,000	6,182,000

413.1 Health Care Access 33,987,000 33,421,000

413.2 Federal TANF 11,713,000 11,713,000

413.3 **Violence Against Asian Women Working**

413.4 **Group.** \$200,000 in fiscal year 2016 from the
413.5 general fund is for the working group on
413.6 violence against Asian women and children.

413.7 **MERC Program.** \$1,000,000 in fiscal year
413.8 2016 and \$1,000,000 in fiscal year 2017 are
413.9 from the general fund for the MERC program
413.10 under Minnesota Statutes, section 62J.692,
413.11 subdivision 4.

413.12 **Poison Information Center Grants.**

413.13 \$750,000 in fiscal year 2016 and \$750,000 in
413.14 fiscal year 2017 are from the general fund for
413.15 regional poison information center grants
413.16 under Minnesota Statutes, section 145.93.

413.17 **Advanced Care Planning.** \$250,000 in fiscal
413.18 year 2016 is from the general fund to award
413.19 a grant to a statewide advance care planning
413.20 resource organization that has expertise in
413.21 convening and coordinating community-based
413.22 strategies to encourage individuals, families,
413.23 caregivers, and health care providers to begin
413.24 conversations regarding end-of-life care
413.25 choices that express an individual's health care
413.26 values and preferences and are based on
413.27 informed health care decisions. This is a
413.28 onetime appropriation.

413.29 **Early Dental Prevention Initiatives.**

413.30 \$172,000 in fiscal year 2016 and \$140,000 in
413.31 fiscal year 2017 are for the development and
413.32 distribution of the early dental prevention
413.33 initiative under Minnesota Statutes, section
413.34 144.3875.

414.1 **International Medical Graduate Assistance**

414.2 **Program.** (a) \$500,000 in fiscal year 2016
414.3 and \$500,000 in fiscal year 2017 are from the
414.4 health care access fund for the grant programs
414.5 and necessary contracts under Minnesota
414.6 Statutes, section 144.1911, subdivisions 3,
414.7 paragraph (a), clause (4), and 4 and 5. The
414.8 commissioner may use up to \$133,000 per
414.9 year of the appropriation for international
414.10 medical graduate assistance program
414.11 administration duties in Minnesota Statutes,
414.12 section 144.1911, subdivisions 3, 9, and 10,
414.13 and for administering the grant programs
414.14 under Minnesota Statutes, section 144.1911,
414.15 subdivisions 4, 5, and 6. The commissioner
414.16 shall develop recommendations for any
414.17 additional funding required for initiatives
414.18 needed to achieve the objectives of Minnesota
414.19 Statutes, section 144.1911. The commissioner
414.20 shall report the funding recommendations to
414.21 the legislature by January 15, 2016, in the
414.22 report required under Minnesota Statutes,
414.23 section 144.1911, subdivision 10. The base
414.24 for this purpose is \$1,000,000 in fiscal years
414.25 2018 and 2019.

414.26 (b) \$500,000 in fiscal year 2016 and \$500,000
414.27 in fiscal year 2017 are from the health care
414.28 access fund for transfer to the revolving
414.29 international medical graduate residency
414.30 account established in Minnesota Statutes,
414.31 section 144.1911, subdivision 6. This is a
414.32 onetime appropriation.

414.33 **Federally Qualified Health Centers.**

414.34 \$1,000,000 in fiscal year 2016 and \$1,000,000
414.35 in fiscal year 2017 are from the general fund

415.1 to provide subsidies to federally qualified
 415.2 health centers under Minnesota Statutes,
 415.3 section 145.9269. This is a onetime
 415.4 appropriation.

415.5 **Organ Donation.** \$200,000 in fiscal year 2016
 415.6 is from the general fund to establish a grant
 415.7 program to develop and create culturally
 415.8 appropriate outreach programs that provide
 415.9 education about the importance of organ
 415.10 donation. Grants shall be awarded to a
 415.11 federally designated organ procurement
 415.12 organization and hospital system that performs
 415.13 transplants. This is a onetime appropriation.

415.14 **Primary Care Residency.** \$1,500,000 in
 415.15 fiscal year 2016 and \$1,500,000 in fiscal year
 415.16 2017 are from the general fund for the
 415.17 purposes of the primary care residency
 415.18 expansion grant program under Minnesota
 415.19 Statutes, section 144.1506.

415.20 ~~**Somali Women's Health Pilot Autism**~~
 415.21 ~~**Program.** (a) The commissioner of health~~
 415.22 ~~shall establish a pilot program between one or~~
 415.23 ~~more federally qualified health centers, as~~
 415.24 ~~defined under Minnesota Statutes, section~~
 415.25 ~~145.9269, a nonprofit organization that helps~~
 415.26 ~~Somali women, and the Minnesota Evaluation~~
 415.27 ~~Studies Institute, to develop a promising~~
 415.28 ~~strategy to address the preventative and~~
 415.29 ~~primary health care needs of, and address~~
 415.30 ~~health inequities experienced by, first~~
 415.31 ~~generation Somali women. The pilot program~~
 415.32 ~~must collaboratively develop a patient flow~~
 415.33 ~~process for first generation Somali women by:~~
 415.34 ~~(1) addressing and identifying clinical and~~
 415.35 ~~cultural barriers to Somali women accessing~~

416.1 ~~preventative and primary care, including, but~~
416.2 ~~not limited to, cervical and breast cancer~~
416.3 ~~screenings;~~

416.4 ~~(2) developing a culturally appropriate health~~
416.5 ~~curriculum for Somali women based on the~~
416.6 ~~outcomes from the community-based~~
416.7 ~~participatory research report "Cultural~~
416.8 ~~Traditions and the Reproductive Health of~~
416.9 ~~Somali Refugees and Immigrants" to increase~~
416.10 ~~the health literacy of Somali women and~~
416.11 ~~develop culturally specific health care~~
416.12 ~~information; and~~

416.13 ~~(3) training the federally qualified health~~
416.14 ~~center's providers and staff to enhance~~
416.15 ~~provider and staff cultural competence~~
416.16 ~~regarding the cultural barriers, including~~
416.17 ~~female genital cutting.~~

416.18 ~~(b) The pilot program must develop a process~~
416.19 ~~that results in increased screening rates for~~
416.20 ~~cervical and breast cancer and can be~~
416.21 ~~replicated by other providers serving ethnic~~
416.22 ~~minorities. The pilot program must conduct~~
416.23 ~~an evaluation of the new patient flow process~~
416.24 ~~used by Somali women to access federally~~
416.25 ~~qualified health centers services award a grant~~
416.26 ~~to Dakota County to partner with a~~
416.27 ~~community-based organization with expertise~~
416.28 ~~in serving Somali children with autism. The~~
416.29 ~~grant must address barriers to accessing health~~
416.30 ~~care and other resources by providing outreach~~
416.31 ~~to Somali families on available support and~~
416.32 ~~training to providers on Somali culture.~~

416.33 ~~(c) The pilot program must report the~~
416.34 ~~outcomes to the commissioner by June 30,~~
416.35 ~~2017.~~

417.1 ~~(d)~~ \$110,000 in fiscal year 2016 is for the
417.2 ~~Somali women's health pilot program grant to~~
417.3 ~~Dakota County.~~ Of this appropriation, the
417.4 commissioner may use up to \$10,000 to
417.5 administer the ~~program grant to Dakota~~
417.6 ~~County.~~ This appropriation is available until
417.7 June 30, 2017. This is a onetime appropriation.

417.8 **Menthol Cigarette Usage in**
417.9 **African-American Community Intervention**
417.10 **Grants.** Of the health care access fund
417.11 appropriation for the statewide health
417.12 improvement program, \$200,000 in fiscal year
417.13 2016 is for at least one grant that must be
417.14 awarded by the commissioner to implement
417.15 strategies and interventions to reduce the
417.16 disproportionately high usage of cigarettes by
417.17 African-Americans, especially the use of
417.18 menthol-flavored cigarettes, as well as the
417.19 disproportionate harm tobacco causes in that
417.20 community. The grantee shall engage
417.21 members of the African-American community
417.22 and community-based organizations. This
417.23 grant shall be awarded as part of the statewide
417.24 health improvement program grants awarded
417.25 on November 1, 2015, and must meet the
417.26 requirements of Minnesota Statutes, section
417.27 145.986.

417.28 **Targeted Home Visiting System.** (a) \$75,000
417.29 in fiscal year 2016 is for the commissioner of
417.30 health, in consultation with the commissioners
417.31 of human services and education, community
417.32 health boards, tribal nations, and other home
417.33 visiting stakeholders, to design baseline
417.34 training for new home visitors to ensure

418.1 statewide coordination across home visiting
418.2 programs.

418.3 (b) \$575,000 in fiscal year 2016 and
418.4 \$2,000,000 fiscal year 2017 are to provide
418.5 grants to community health boards and tribal
418.6 nations for start-up grants for new
418.7 nurse-family partnership programs and for
418.8 grants to expand existing programs to serve
418.9 first-time mothers, prenatally by 28 weeks
418.10 gestation until the child is two years of age,
418.11 who are eligible for medical assistance under
418.12 Minnesota Statutes, chapter 256B, or the
418.13 federal Special Supplemental Nutrition
418.14 Program for Women, Infants, and Children.

418.15 The commissioner shall award grants to
418.16 community health boards or tribal nations in
418.17 metropolitan and rural areas of the state.

418.18 Priority for all grants shall be given to
418.19 nurse-family partnership programs that
418.20 provide services through a Minnesota health
418.21 care program-enrolled provider that accepts
418.22 medical assistance. Additionally, priority for
418.23 grants to rural areas shall be given to
418.24 community health boards and tribal nations
418.25 that expand services within regional
418.26 partnerships that provide the nurse-family
418.27 partnership program. Funding available under
418.28 this paragraph may only be used to
418.29 supplement, not to replace, funds being used
418.30 for nurse-family partnership home visiting
418.31 services as of June 30, 2015.

418.32 **Opiate Antagonists.** \$270,000 in fiscal year
418.33 2016 and \$20,000 in fiscal year 2017 are from
418.34 the general fund for grants to the eight regional
418.35 emergency medical services programs to

419.1 purchase opiate antagonists and educate and
419.2 train emergency medical services persons, as
419.3 defined in Minnesota Statutes, section
419.4 144.7401, subdivision 4, clauses (1) and (2),
419.5 in the use of these antagonists in the event of
419.6 an opioid or heroin overdose. For the purposes
419.7 of this paragraph, "opiate antagonist" means
419.8 naloxone hydrochloride or any similarly acting
419.9 drug approved by the federal Food and Drug
419.10 Administration for the treatment of drug
419.11 overdose. Grants under this paragraph must
419.12 be distributed to all eight regional emergency
419.13 medical services programs. This is a onetime
419.14 appropriation and is available until June 30,
419.15 2017. The commissioner may use up to
419.16 \$20,000 of the amount for opiate antagonists
419.17 for administration.

419.18 **Local and Tribal Public Health Grants.** (a)
419.19 \$894,000 in fiscal year 2016 and \$894,000 in
419.20 fiscal year 2017 are for an increase in local
419.21 public health grants for community health
419.22 boards under Minnesota Statutes, section
419.23 145A.131, subdivision 1, paragraph (e).

419.24 (b) \$106,000 in fiscal year 2016 and \$106,000
419.25 in fiscal year 2017 are for an increase in
419.26 special grants to tribal governments under
419.27 Minnesota Statutes, section 145A.14,
419.28 subdivision 2a.

419.29 **HCBS Employee Scholarships.** \$1,000,000
419.30 in fiscal year 2016 and \$1,000,000 in fiscal
419.31 year 2017 are from the general fund for the
419.32 home and community-based services
419.33 employee scholarship program under
419.34 Minnesota Statutes, section 144.1503. The
419.35 commissioner may use up to \$50,000 of the

420.1 amount for the HCBS employee scholarships
420.2 for administration.

420.3 **Family Planning Special Projects.**

420.4 \$1,000,000 in fiscal year 2016 and \$1,000,000
420.5 in fiscal year 2017 are from the general fund
420.6 for family planning special project grants
420.7 under Minnesota Statutes, section 145.925.

420.8 **Positive Alternatives.** \$1,000,000 in fiscal
420.9 year 2016 and \$1,000,000 in fiscal year 2017
420.10 are from the general fund for positive abortion
420.11 alternatives under Minnesota Statutes, section
420.12 145.4235.

420.13 **Safe Harbor for Sexually Exploited Youth.**

420.14 \$700,000 in fiscal year 2016 and \$700,000 in
420.15 fiscal year 2017 are from the general fund for
420.16 the safe harbor program under Minnesota
420.17 Statutes, sections 145.4716 to 145.4718. Funds
420.18 shall be used for grants to increase the number
420.19 of regional navigators; training for
420.20 professionals who engage with exploited or
420.21 at-risk youth; implementing statewide
420.22 protocols and best practices for effectively
420.23 identifying, interacting with, and referring
420.24 sexually exploited youth to appropriate
420.25 resources; and program operating costs.

420.26 **Health Care Grants for Uninsured**

420.27 **Individuals.** (a) \$62,500 in fiscal year 2016
420.28 and \$62,500 in fiscal year 2017 are from the
420.29 health care access fund for dental provider
420.30 grants in Minnesota Statutes, section 145.929,
420.31 subdivision 1.

420.32 (b) \$218,750 in fiscal year 2016 and \$218,750
420.33 in fiscal year 2017 are from the health care
420.34 access fund for community mental health

421.1 program grants in Minnesota Statutes, section
421.2 145.929, subdivision 2.

421.3 (c) \$750,000 in fiscal year 2016 and \$750,000
421.4 in fiscal year 2017 are from the health care
421.5 access fund for the emergency medical
421.6 assistance outlier grant program in Minnesota
421.7 Statutes, section 145.929, subdivision 3.

421.8 (d) \$218,750 of the health care access fund
421.9 appropriation in fiscal year 2016 and \$218,750
421.10 in fiscal year 2017 are for community health
421.11 center grants under Minnesota Statutes, section
421.12 145.9269. A community health center that
421.13 receives a grant from this appropriation is not
421.14 eligible for a grant under paragraph (b).

421.15 (e) The commissioner may use up to \$25,000
421.16 of the appropriations for health care grants for
421.17 uninsured individuals in fiscal years 2016 and
421.18 2017 for grant administration.

421.19 **TANF Appropriations.** (a) \$1,156,000 of the
421.20 TANF funds is appropriated each year of the
421.21 biennium to the commissioner for family
421.22 planning grants under Minnesota Statutes,
421.23 section 145.925.

421.24 (b) \$3,579,000 of the TANF funds is
421.25 appropriated each year of the biennium to the
421.26 commissioner for home visiting and nutritional
421.27 services listed under Minnesota Statutes,
421.28 section 145.882, subdivision 7, clauses (6) and
421.29 (7). Funds must be distributed to community
421.30 health boards according to Minnesota Statutes,
421.31 section 145A.131, subdivision 1.

421.32 (c) \$2,000,000 of the TANF funds is
421.33 appropriated each year of the biennium to the
421.34 commissioner for decreasing racial and ethnic

422.1 disparities in infant mortality rates under
422.2 Minnesota Statutes, section 145.928,
422.3 subdivision 7.

422.4 (d) \$4,978,000 of the TANF funds is
422.5 appropriated each year of the biennium to the
422.6 commissioner for the family home visiting
422.7 grant program according to Minnesota
422.8 Statutes, section 145A.17. \$4,000,000 of the
422.9 funding must be distributed to community
422.10 health boards according to Minnesota Statutes,
422.11 section 145A.131, subdivision 1. \$978,000 of
422.12 the funding must be distributed to tribal
422.13 governments as provided in Minnesota
422.14 Statutes, section 145A.14, subdivision 2a.

422.15 (e) The commissioner may use up to 6.23
422.16 percent of the funds appropriated each fiscal
422.17 year to conduct the ongoing evaluations
422.18 required under Minnesota Statutes, section
422.19 145A.17, subdivision 7, and training and
422.20 technical assistance as required under
422.21 Minnesota Statutes, section 145A.17,
422.22 subdivisions 4 and 5.

422.23 **TANF Carryforward.** Any unexpended
422.24 balance of the TANF appropriation in the first
422.25 year of the biennium does not cancel but is
422.26 available for the second year.

422.27 **Health Professional Loan Forgiveness.**
422.28 \$2,631,000 in fiscal year 2016 and \$2,631,000
422.29 in fiscal year 2017 are from the health care
422.30 access fund for the purposes of Minnesota
422.31 Statutes, section 144.1501. Of this
422.32 appropriation, the commissioner may use up
422.33 to \$131,000 each year to administer the
422.34 program.

423.1 **Minnesota Stroke System.** \$350,000 in fiscal
423.2 year 2016 and \$350,000 in fiscal year 2017
423.3 are from the general fund for the Minnesota
423.4 stroke system.

423.5 **Prevention of Violence in Health Care.**
423.6 \$50,000 in fiscal year 2016 is to continue the
423.7 prevention of violence in health care program
423.8 and creating violence prevention resources for
423.9 hospitals and other health care providers to
423.10 use in training their staff on violence
423.11 prevention. This is a onetime appropriation
423.12 and is available until June 30, 2017.

423.13 **Health Care Savings Determinations. (a)**
423.14 The health care access fund base for the state
423.15 health improvement program is decreased by
423.16 \$261,000 in fiscal year 2016 and decreased
423.17 by \$110,000 in fiscal year 2017.

423.18 (b) \$261,000 in fiscal year 2016 and \$110,000
423.19 in fiscal year 2017 are from the health care
423.20 access fund for the forecasting, cost reporting,
423.21 and analysis required by Minnesota Statutes,
423.22 section 62U.10, subdivisions 6 and 7.

423.23 **Base Level Adjustments.** The general fund
423.24 base is decreased by \$1,070,000 in fiscal year
423.25 2018 and by \$1,020,000 in fiscal year 2019.
423.26 The state government special revenue fund
423.27 base is increased by \$33,000 in fiscal year
423.28 2018. The health care access fund base is
423.29 increased by \$610,000 in fiscal year 2018 and
423.30 by \$23,000 in fiscal year 2019.

423.31 **Sec. 74. STUDY AND REPORT ON HOME CARE NURSING WORKFORCE**
423.32 **SHORTAGE.**

423.33 **(a) The chair and ranking minority member of the senate Human Services Reform**
423.34 **Finance and Policy Committee and the chair and ranking minority member of the house of**

424.1 representatives Health and Human Services Finance Committee shall convene a working
424.2 group to study and report on the shortage of registered nurses and licensed practical nurses
424.3 available to provide low-complexity regular home care services to clients in need of such
424.4 services, especially clients covered by medical assistance, and to provide recommendations
424.5 for ways to address the workforce shortage. The working group shall consist of 12 members
424.6 appointed as follows:

424.7 (1) the chair of the senate Human Services Reform Finance and Policy Committee or a
424.8 designee;

424.9 (2) the ranking minority member of the senate Human Services Reform Finance and
424.10 Policy Committee or a designee;

424.11 (3) the chair of the house of representatives Health and Human Services Finance
424.12 Committee or a designee;

424.13 (4) the ranking minority member of the house of representatives Health and Human
424.14 Services Finance Committee or a designee;

424.15 (5) the commissioner of human services or a designee;

424.16 (6) the commissioner of health or a designee;

424.17 (7) one representative appointed by the Professional Home Care Coalition;

424.18 (8) one representative appointed by the Minnesota Home Care Association;

424.19 (9) one representative appointed by the Minnesota Board of Nursing;

424.20 (10) one representative appointed by the Minnesota Nurses Association;

424.21 (11) one representative appointed by the Minnesota Licensed Practical Nurses
424.22 Association;

424.23 (12) one representative appointed by the Minnesota Society of Medical Assistants;

424.24 (13) one client who receives regular home care nursing services and is covered by medical
424.25 assistance appointed by the commissioner of human services after consulting with the
424.26 appointing authorities identified in clauses (7) to (12); and

424.27 (14) one county public health nurse who is a certified assessor appointed by the
424.28 commissioner of health after consulting with the Minnesota Home Care Association.

424.29 (b) The appointing authorities must appoint members by August 1, 2017.

424.30 (c) The convening authorities shall convene the first meeting of the working group no
424.31 later than August 15, 2017, and caucus staff shall provide support and meeting space for

425.1 the working group. The Department of Health and the Department of Human Services shall
425.2 provide technical assistance to the working group, including providing data documenting
425.3 the current and projected workforce shortages in the area of regular home care nursing. The
425.4 home care and assisted living program advisory council established under Minnesota Statutes,
425.5 section 144A.4799, shall provide advice and recommendations to the working group.
425.6 Working group members shall serve without compensation and shall not be reimbursed for
425.7 expenses.

425.8 (d) The working group shall:

425.9 (1) quantify the number of low-complexity regular home care nursing hours that are
425.10 authorized but not provided to clients covered by medical assistance, due to the shortage
425.11 of registered nurses and licensed practical nurses available to provide these home care
425.12 services;

425.13 (2) quantify the current and projected workforce shortages of registered nurses and
425.14 licensed practical nurses available to provide low-complexity regular home care nursing
425.15 services to clients, especially clients covered by medical assistance;

425.16 (3) develop recommendations for actions to take in the next two years to address the
425.17 regular home care nursing workforce shortage, including identifying other health care
425.18 professionals who may be able to provide low-complexity regular home care nursing services
425.19 with additional training; what additional training may be necessary for these health care
425.20 professionals; and how to address scope of practice and licensing issues;

425.21 (4) compile reimbursement rates for regular home care nursing from other states and
425.22 determine Minnesota's national ranking with respect to reimbursement for regular home
425.23 care nursing;

425.24 (5) determine whether reimbursement rates for regular home care nursing fully reimburse
425.25 providers for the cost of providing the service and whether the discrepancy, if any, between
425.26 rates and costs contributes to lack of access to regular home care nursing; and

425.27 (6) by January 15, 2018, report on the findings and recommendations of the working
425.28 group to the chairs and ranking minority members of the legislative committees with
425.29 jurisdiction over health and human services policy and finance. The working group's report
425.30 shall include draft legislation.

425.31 (e) The working group shall elect a chair from among its members at its first meeting.

425.32 (f) The meetings of the working group shall be open to the public.

426.1 (g) This section expires January 16, 2018, or the day after submitting the report required
426.2 by this section, whichever is earlier.

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

426.4 Sec. 75. **ACCOUNTABLE COMMUNITY FOR HEALTH OPIOID ABUSE**
426.5 **PREVENTION PILOT PROJECTS.**

426.6 (a) The commissioner of health shall establish up to 12 opioid abuse prevention pilot
426.7 projects that provide innovative and collaborative solutions to confront opioid abuse. Each
426.8 pilot project must:

426.9 (1) be designed to reduce emergency room and other health care provider visits resulting
426.10 from opioid use or abuse, and reduce rates of opioid addiction in the community;

426.11 (2) establish multidisciplinary controlled substance care teams that may consist of
426.12 physicians, pharmacists, social workers, nurse care coordinators, and mental health
426.13 professionals;

426.14 (3) deliver health care services and care coordination, through controlled substance care
426.15 teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

426.16 (4) address any unmet social service needs that create barriers to managing pain
426.17 effectively and obtaining optimal health outcomes;

426.18 (5) provide prescriber and dispenser education and assistance to reduce the inappropriate
426.19 prescribing and dispensing of opioids;

426.20 (6) promote the adoption of best practices related to opioid disposal and reducing
426.21 opportunities for illegal access to opioids; and

426.22 (7) engage partners outside of the health care system, including schools, law enforcement,
426.23 and social services, to address root causes of opioid abuse and addiction at the community
426.24 level.

426.25 (b) The commissioner shall contract with an accountable community for health that
426.26 operates an opioid abuse prevention project and can document success in reducing opioid
426.27 use through the use of controlled substance care teams, to assist the commissioner in
426.28 administering this section and to provide technical assistance to the commissioner and to
426.29 entities selected to operate a pilot project.

426.30 (c) The contract under paragraph (b) shall require the accountable community for health
426.31 to evaluate the extent to which the pilot projects were successful in reducing the inappropriate
426.32 use of opioids. The evaluation must analyze changes in the number of opioid prescriptions,

427.1 the number of emergency room visits related to opioid use, and other relevant measures.

427.2 The accountable community for health shall report evaluation results to the chairs and

427.3 ranking minority members of the legislative committees with jurisdiction over health and

427.4 human services policy and finance and public safety by December 15, 2019.

427.5 Sec. 76. **COMPREHENSIVE PLAN TO END HIV/AIDS.**

427.6 (a) The commissioner of health, in coordination with the commissioner of human services,

427.7 and in consultation with community stakeholders, shall develop a strategic statewide

427.8 comprehensive plan that establishes a set of priorities and actions to address the state's HIV

427.9 epidemic by reducing the number of newly infected individuals; ensuring that individuals

427.10 living with HIV have access to quality, life-extending care regardless of race, gender, sexual

427.11 orientation, or socioeconomic circumstances; and ensuring the coordination of a statewide

427.12 response to reach the ultimate goal of the elimination of HIV in Minnesota.

427.13 (b) The plan must identify strategies that are consistent with the National HIV/AIDS

427.14 Strategy plan, that reflect the scientific developments in HIV medical care and prevention

427.15 that have occurred, and that work toward the elimination of HIV. The plan must:

427.16 (1) determine the appropriate level of testing, care, and services necessary to achieve

427.17 the goal of the elimination of HIV, beginning with meeting the following outcomes:

427.18 (i) reduce the number of new diagnoses by at least 75 percent;

427.19 (ii) increase the percentage of individuals living with HIV who know their serostatus to

427.20 at least 90 percent;

427.21 (iii) increase the percentage of individuals living with HIV who are receiving HIV

427.22 treatment to at least 90 percent; and

427.23 (iv) increase the percentage of individuals living with HIV who are virally suppressed

427.24 to at least 90 percent;

427.25 (2) provide recommendations for the optimal allocation and alignment of existing state

427.26 and federal funding in order to achieve the greatest impact and ensure a coordinated statewide

427.27 effort; and

427.28 (3) provide recommendations for evaluating new and enhanced interventions and an

427.29 estimate of additional resources needed to provide these interventions.

427.30 (c) The commissioner shall submit the comprehensive plan and recommendations to the

427.31 chairs and ranking minority members of the legislative committees with jurisdiction over

427.32 health and human services policy and finance by February 1, 2018.

428.1 (d) The commissioner, after consulting with stakeholders, may implement this section
428.2 utilizing existing efforts being carried out for similar purposes in order to reduce the resources
428.3 required to implement this section.

428.4 **Sec. 77. SAFE HARBOR FOR ALL; STATEWIDE SEX TRAFFICKING VICTIMS**
428.5 **STRATEGIC PLAN.**

428.6 (a) By October 1, 2018, the commissioner of health, in consultation with the
428.7 commissioners of public safety and human services, shall develop a comprehensive strategic
428.8 plan to address the needs of sex trafficking victims statewide.

428.9 (b) In developing the plan, the commissioner of health shall seek recommendations from
428.10 professionals, community members, and stakeholders from across the state, with an emphasis
428.11 on the communities most impacted by sex trafficking. At a minimum, the commissioner
428.12 must seek input from the following groups: sex trafficking survivors and their family
428.13 members, statewide crime victim services coalitions, victim services providers, nonprofit
428.14 organizations, task forces, prosecutors, public defenders, tribal governments, public safety
428.15 and corrections professionals, public health professionals, human services professionals,
428.16 and impacted community members.

428.17 (c) By January 15, 2019, the commissioner of health shall report to the chairs and ranking
428.18 minority members of the legislative committees with jurisdiction over health and human
428.19 services and criminal justice finance and policy on developing the statewide strategic plan,
428.20 including recommendations for additional legislation and funding. The report must contain
428.21 policy considerations regarding decriminalization of Minnesota Statutes, section 609.324,
428.22 subdivisions 6 and 7.

428.23 (d) As used in this section, "sex trafficking victim" has the meaning given in Minnesota
428.24 Statutes, section 609.321, subdivision 7b.

428.25 **Sec. 78. DIRECTION TO THE COMMISSIONER OF HEALTH.**

428.26 The commissioner of health shall work with interested stakeholders to evaluate whether
428.27 existing laws, including laws governing housing with services establishments, board and
428.28 lodging establishments with special services, assisted living designations, and home care
428.29 providers, as well as building code requirements and landlord tenancy laws, sufficiently
428.30 protect the health and safety of persons diagnosed with Alzheimer's disease or a related
428.31 dementia.

429.1 **Sec. 79. PALLIATIVE CARE ADVISORY COUNCIL.**

429.2 The appointing authorities shall appoint the first members of the Palliative Care Advisory
 429.3 Council under Minnesota Statutes, section 144.059, by October 1, 2017. The commissioner
 429.4 of health shall convene the first meeting by November 15, 2017, and the commissioner or
 429.5 the commissioner's designee shall act as chair until the council elects a chair at its first
 429.6 meeting.

429.7 **Sec. 80. COUNTY-BASED PURCHASING PLANS.**

429.8 The commissioner of health shall explore ways to allow county-based purchasing plans
 429.9 meeting the requirements under Minnesota Statutes, section 256B.692, to sell health insurance
 429.10 coverage in the individual and group health insurance markets.

429.11 **Sec. 81. REPEALER.**

429.12 Laws 2014, chapter 312, article 23, section 9, subdivision 5, is repealed.

429.13 **ARTICLE 11**

429.14 **HEALTH LICENSING BOARDS**

429.15 Section 1. Minnesota Statutes 2016, section 147.01, subdivision 7, is amended to read:

429.16 Subd. 7. **Physician application fee and license fees.** (a) The board may charge a the
 429.17 following nonrefundable application and license fees processed pursuant to sections 147.02,
 429.18 147.03, 147.037, 147.0375, and 147.38:

429.19 (1) physician application fee of, \$200;

429.20 (2) physician annual registration renewal fee, \$192;

429.21 (3) physician endorsement to other states, \$40;

429.22 (4) physician emeritus license, \$50;

429.23 (5) physician temporary licenses, \$60;

429.24 (6) physician late fee, \$60;

429.25 (7) duplicate license fee, \$20;

429.26 (8) certification letter fee, \$25;

429.27 (9) education or training program approval fee, \$100;

429.28 (10) report creation and generation fee, \$60;

430.1 (11) examination administration fee (half day), \$50;

430.2 (12) examination administration fee (full day), \$80; and

430.3 (13) fees developed by the Interstate Commission for determining physician qualification
430.4 to register and participate in the interstate medical licensure compact, as established in rules
430.5 authorized in and pursuant to section 147.38, not to exceed \$1,000.

430.6 (b) The board may prorate the initial annual license fee. All licensees are required to
430.7 pay the full fee upon license renewal. The revenue generated from the fee must be deposited
430.8 in an account in the state government special revenue fund.

430.9 Sec. 2. Minnesota Statutes 2016, section 147.02, subdivision 1, is amended to read:

430.10 Subdivision 1. **United States or Canadian medical school graduates.** The board shall
430.11 issue a license to practice medicine to a person not currently licensed in another state or
430.12 Canada and who meets the requirements in paragraphs (a) to (i).

430.13 (a) An applicant for a license shall file a written application on forms provided by the
430.14 board, showing to the board's satisfaction that the applicant is of good moral character and
430.15 satisfies the requirements of this section.

430.16 (b) The applicant shall present evidence satisfactory to the board of being a graduate of
430.17 a medical or osteopathic medical school located in the United States, its territories or Canada,
430.18 and approved by the board based upon its faculty, curriculum, facilities, accreditation by a
430.19 recognized national accrediting organization approved by the board, and other relevant data,
430.20 or is currently enrolled in the final year of study at the school.

430.21 (c) The applicant must have passed an examination as described in clause (1) or (2).

430.22 (1) The applicant must have passed a comprehensive examination for initial licensure
430.23 prepared and graded by the National Board of Medical Examiners, the Federation of State
430.24 Medical Boards, the Medical Council of Canada, the National Board of Osteopathic
430.25 Examiners, or the appropriate state board that the board determines acceptable. The board
430.26 shall by rule determine what constitutes a passing score in the examination.

430.27 (2) The applicant taking the United States Medical Licensing Examination (USMLE)
430.28 or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must
430.29 have passed steps or levels one, two, and three. Step or level three must be passed within
430.30 five years of passing step or level two, or before the end of residency training. The applicant
430.31 must pass each of steps or levels one, two, and three with passing scores as recommended
430.32 by the USMLE program or National Board of Osteopathic Medical Examiners within three

431.1 attempts. The applicant taking combinations of Federation of State Medical Boards, National
431.2 Board of Medical Examiners, and USMLE may be accepted only if the combination is
431.3 approved by the board as comparable to existing comparable examination sequences and
431.4 all examinations are completed prior to the year 2000.

431.5 (d) The applicant shall present evidence satisfactory to the board of the completion of
431.6 one year of graduate, clinical medical training in a program accredited by a national
431.7 accrediting organization approved by the board or other graduate training approved in
431.8 advance by the board as meeting standards similar to those of a national accrediting
431.9 organization.

431.10 (e) The applicant may make arrangements with the executive director to appear in person
431.11 before the board or its designated representative to show that the applicant satisfies the
431.12 requirements of this section. The board may establish as internal operating procedures the
431.13 procedures or requirements for the applicant's personal presentation.

431.14 (f) The applicant shall pay a nonrefundable fee established by the board ~~by rule~~. The
431.15 ~~fee may not be refunded~~. Upon application or notice of license renewal, the board must
431.16 provide notice to the applicant and to the person whose license is scheduled to be issued or
431.17 renewed of any additional fees, surcharges, or other costs which the person is obligated to
431.18 pay as a condition of licensure. The notice must:

431.19 (1) state the dollar amount of the additional costs; and

431.20 (2) clearly identify to the applicant the payment schedule of additional costs.

431.21 (g) The applicant must not be under license suspension or revocation by the licensing
431.22 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
431.23 occurred.

431.24 (h) The applicant must not have engaged in conduct warranting disciplinary action
431.25 against a licensee, or have been subject to disciplinary action other than as specified in
431.26 paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph,
431.27 the board may issue a license only on the applicant's showing that the public will be protected
431.28 through issuance of a license with conditions and limitations the board considers appropriate.

431.29 (i) If the examination in paragraph (c) was passed more than ten years ago, the applicant
431.30 must either:

431.31 (1) pass the special purpose examination of the Federation of State Medical Boards with
431.32 a score of 75 or better within three attempts; or

432.1 (2) have a current certification by a specialty board of the American Board of Medical
432.2 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
432.3 Surgeons of Canada, or of the College of Family Physicians of Canada.

432.4 Sec. 3. Minnesota Statutes 2016, section 147.03, subdivision 1, is amended to read:

432.5 Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice
432.6 medicine to any person who satisfies the requirements in paragraphs (b) to ~~(f)~~(e).

432.7 (b) The applicant shall satisfy all the requirements established in section 147.02,
432.8 subdivision 1, paragraphs (a), (b), (d), (e), and (f).

432.9 (c) The applicant shall:

432.10 (1) have passed an examination prepared and graded by the Federation of State Medical
432.11 Boards, the National Board of Medical Examiners, or the United States Medical Licensing
432.12 Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph
432.13 (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council
432.14 of Canada; and

432.15 (2) have a current license from the equivalent licensing agency in another state or Canada
432.16 and, if the examination in clause (1) was passed more than ten years ago, either:

432.17 (i) pass the Special Purpose Examination of the Federation of State Medical Boards with
432.18 a score of 75 or better within three attempts; or

432.19 (ii) have a current certification by a specialty board of the American Board of Medical
432.20 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
432.21 Surgeons of Canada, or of the College of Family Physicians of Canada; or

432.22 (3) if the applicant fails to meet the requirement established in section 147.02, subdivision
432.23 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and
432.24 three of the USMLE within the required three attempts, the applicant may be granted a
432.25 license provided the applicant:

432.26 (i) has passed each of steps one, two, and three with passing scores as recommended by
432.27 the USMLE program within no more than four attempts for any of the three steps;

432.28 (ii) is currently licensed in another state; and

432.29 (iii) has current certification by a specialty board of the American Board of Medical
432.30 Specialties, the American Osteopathic Association Bureau of Professional Education, the
432.31 Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians
432.32 of Canada.

433.1 ~~(d) The applicant shall pay a fee established by the board by rule. The fee may not be~~
 433.2 ~~refunded.~~

433.3 ~~(e)~~ (d) The applicant must not be under license suspension or revocation by the licensing
 433.4 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
 433.5 occurred.

433.6 ~~(f)~~ (e) The applicant must not have engaged in conduct warranting disciplinary action
 433.7 against a licensee, or have been subject to disciplinary action other than as specified in
 433.8 paragraph ~~(e)~~(d). If an applicant does not satisfy the requirements stated in this paragraph,
 433.9 the board may issue a license only on the applicant's showing that the public will be protected
 433.10 through issuance of a license with conditions or limitations the board considers appropriate.

433.11 ~~(g)~~ (f) Upon the request of an applicant, the board may conduct the final interview of
 433.12 the applicant by teleconference.

433.13 Sec. 4. **[147A.28] PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.**

433.14 (a) The board may charge the following nonrefundable fees:

433.15 (1) physician assistant application fee, \$120;

433.16 (2) physician assistant annual registration renewal fee (prescribing authority), \$135;

433.17 (3) physician assistant annual registration renewal fee (no prescribing authority), \$115;

433.18 (4) physician assistant temporary registration, \$115;

433.19 (5) physician assistant temporary permit, \$60;

433.20 (6) physician assistant locum tenens permit, \$25;

433.21 (7) physician assistant late fee, \$50;

433.22 (8) duplicate license fee, \$20;

433.23 (9) certification letter fee, \$25;

433.24 (10) education or training program approval fee, \$100; and

433.25 (11) report creation and generation fee, \$60.

433.26 (b) The board may prorate the initial annual license fee. All licensees are required to
 433.27 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
 433.28 in an account in the state government special revenue fund.

434.1 Sec. 5. Minnesota Statutes 2016, section 147B.08, is amended by adding a subdivision to
434.2 read:

434.3 Subd. 4. **Acupuncturist application and license fees.** (a) The board may charge the
434.4 following nonrefundable fees:

434.5 (1) acupuncturist application fee, \$150;

434.6 (2) acupuncturist annual registration renewal fee, \$150;

434.7 (3) acupuncturist temporary registration fee, \$60;

434.8 (4) acupuncturist inactive status fee, \$50;

434.9 (5) acupuncturist late fee, \$50;

434.10 (6) duplicate license fee, \$20;

434.11 (7) certification letter fee, \$25;

434.12 (8) education or training program approval fee, \$100; and

434.13 (9) report creation and generation fee, \$60.

434.14 (b) The board may prorate the initial annual license fee. All licensees are required to
434.15 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
434.16 in an account in the state government special revenue fund.

434.17 Sec. 6. Minnesota Statutes 2016, section 147C.40, is amended by adding a subdivision to
434.18 read:

434.19 Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge
434.20 the following nonrefundable fees:

434.21 (1) respiratory therapist application fee, \$100;

434.22 (2) respiratory therapist annual registration renewal fee, \$90;

434.23 (3) respiratory therapist inactive status fee, \$50;

434.24 (4) respiratory therapist temporary registration fee, \$90;

434.25 (5) respiratory therapist temporary permit, \$60;

434.26 (6) respiratory therapist late fee, \$50;

434.27 (7) duplicate license fee, \$20;

434.28 (8) certification letter fee, \$25;

435.1 (9) education or training program approval fee, \$100; and

435.2 (10) report creation and generation fee, \$60.

435.3 (b) The board may prorate the initial annual license fee. All licensees are required to
435.4 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
435.5 in an account in the state government special revenue fund.

435.6 Sec. 7. Minnesota Statutes 2016, section 148.6402, subdivision 4, is amended to read:

435.7 Subd. 4. ~~Commissioner Board.~~ "Commissioner Board" means the ~~commissioner of~~
435.8 ~~health or a designee~~ Board of Occupational Therapy Practice established in section 148.6449.

435.9 EFFECTIVE DATE. This section is effective January 1, 2018.

435.10 Sec. 8. Minnesota Statutes 2016, section 148.6405, is amended to read:

435.11 **148.6405 LICENSURE APPLICATION REQUIREMENTS: PROCEDURES AND**
435.12 **QUALIFICATIONS.**

435.13 (a) An applicant for licensure must comply with the application requirements in section
435.14 148.6420. To qualify for licensure, an applicant must satisfy one of the requirements in
435.15 paragraphs (b) to (f) and not be subject to denial of licensure under section 148.6448.

435.16 (b) A person who applies for licensure as an occupational therapist and who has not
435.17 been credentialed by the National Board for Certification in Occupational Therapy or another
435.18 jurisdiction must meet the requirements in section 148.6408.

435.19 (c) A person who applies for licensure as an occupational therapy assistant and who has
435.20 not been credentialed by the National Board for Certification in Occupational Therapy or
435.21 another jurisdiction must meet the requirements in section 148.6410.

435.22 (d) A person who is certified by the National Board for Certification in Occupational
435.23 Therapy may apply for licensure by equivalency and must meet the requirements in section
435.24 148.6412.

435.25 (e) A person who is credentialed in another jurisdiction may apply for licensure by
435.26 reciprocity and must meet the requirements in section 148.6415.

435.27 (f) A person who applies for temporary licensure must meet the requirements in section
435.28 148.6418.

436.1 (g) A person who applies for licensure under paragraph (b), (c), or (f) more than two
436.2 and less than four years after meeting the requirements in section 148.6408 or 148.6410
436.3 must submit the following:

436.4 (1) a completed and signed application for licensure on forms provided by the
436.5 ~~commissioner~~ board;

436.6 (2) the license application fee required under section 148.6445;

436.7 (3) if applying for occupational therapist licensure, proof of having met a minimum of
436.8 24 contact hours of continuing education in the two years preceding licensure application,
436.9 or if applying for occupational therapy assistant licensure, proof of having met a minimum
436.10 of 18 contact hours of continuing education in the two years preceding licensure application;

436.11 (4) verified documentation of successful completion of 160 hours of supervised practice
436.12 approved by the ~~commissioner~~ board under a limited license specified in section 148.6425,
436.13 subdivision 3, paragraph (c); and

436.14 (5) additional information as requested by the ~~commissioner~~ board to clarify information
436.15 in the application, including information to determine whether the individual has engaged
436.16 in conduct warranting disciplinary action under section 148.6448. The information must be
436.17 submitted within 30 days after the ~~commissioner's~~ board's request.

436.18 (h) A person who applied for licensure under paragraph (b), (c), or (f) four years or more
436.19 after meeting the requirements in section 148.6408 or 148.6410 must meet all the
436.20 requirements in paragraph (g) except clauses (3) and (4), submit documentation of having
436.21 retaken and passed the credentialing examination for occupational therapist or occupational
436.22 therapy assistant, or of having completed an occupational therapy refresher program that
436.23 contains both a theoretical and clinical component approved by the ~~commissioner~~ board,
436.24 and verified documentation of successful completion of 480 hours of supervised practice
436.25 approved by the ~~commissioner~~ board under a limited license specified in section 148.6425,
436.26 subdivision 3, paragraph (c). The 480 hours of supervised practice must be completed in
436.27 six months and may be completed at the applicant's place of work. Only refresher courses
436.28 completed within one year prior to the date of application qualify for approval.

436.29 **EFFECTIVE DATE.** This section is effective January 1, 2018.

436.30 Sec. 9. Minnesota Statutes 2016, section 148.6408, subdivision 2, is amended to read:

436.31 Subd. 2. **Qualifying examination score required.** (a) An applicant must achieve a
436.32 qualifying score on the credentialing examination for occupational therapist.

437.1 (b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing
437.2 examination for occupational therapist. In determining the qualifying score, the ~~commissioner~~
437.3 board shall consider the cut score recommended by the National Board for Certification in
437.4 Occupational Therapy, or other national credentialing organization approved by the
437.5 ~~commissioner~~ board, using the modified Angoff method for determining cut score or another
437.6 method for determining cut score that is recognized as appropriate and acceptable by industry
437.7 standards.

437.8 (c) The applicant is responsible for:

437.9 (1) making arrangements to take the credentialing examination for occupational therapist;

437.10 (2) bearing all expenses associated with taking the examination; and

437.11 (3) having the examination scores sent directly to the ~~commissioner~~ board from the
437.12 testing service that administers the examination.

437.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

437.14 Sec. 10. Minnesota Statutes 2016, section 148.6410, subdivision 2, is amended to read:

437.15 Subd. 2. **Qualifying examination score required.** (a) An applicant for licensure must
437.16 achieve a qualifying score on the credentialing examination for occupational therapy
437.17 assistants.

437.18 (b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing
437.19 examination for occupational therapy assistants. In determining the qualifying score, the
437.20 ~~commissioner~~ board shall consider the cut score recommended by the National Board for
437.21 Certification in Occupational Therapy, or other national credentialing organization approved
437.22 by the ~~commissioner~~ board, using the modified Angoff method for determining cut score
437.23 or another method for determining cut score that is recognized as appropriate and acceptable
437.24 by industry standards.

437.25 (c) The applicant is responsible for:

437.26 (1) making all arrangements to take the credentialing examination for occupational
437.27 therapy assistants;

437.28 (2) bearing all expense associated with taking the examination; and

437.29 (3) having the examination scores sent directly to the ~~commissioner~~ board from the
437.30 testing service that administers the examination.

437.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

438.1 Sec. 11. Minnesota Statutes 2016, section 148.6412, subdivision 2, is amended to read:

438.2 Subd. 2. **Persons certified by National Board for Certification in Occupational**
438.3 **Therapy after June 17, 1996.** The ~~commissioner~~ board may license any person certified
438.4 by the National Board for Certification in Occupational Therapy as an occupational therapist
438.5 after June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification
438.6 are equivalent to or exceed the requirements for licensure as an occupational therapist under
438.7 section 148.6408. The ~~commissioner~~ board may license any person certified by the National
438.8 Board for Certification in Occupational Therapy as an occupational therapy assistant after
438.9 June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification are
438.10 equivalent to or exceed the requirements for licensure as an occupational therapy assistant
438.11 under section 148.6410. Nothing in this section limits the ~~commissioner's~~ board's authority
438.12 to deny licensure based upon the grounds for discipline in sections 148.6401 to 148.6450.

438.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

438.14 Sec. 12. Minnesota Statutes 2016, section 148.6415, is amended to read:

438.15 **148.6415 LICENSURE BY RECIPROCIITY.**

438.16 A person who holds a current credential as an occupational therapist in the District of
438.17 Columbia or a state or territory of the United States whose standards for credentialing are
438.18 determined by the ~~commissioner~~ board to be equivalent to or exceed the requirements for
438.19 licensure under section 148.6408 may be eligible for licensure by reciprocity as an
438.20 occupational therapist. A person who holds a current credential as an occupational therapy
438.21 assistant in the District of Columbia or a state or territory of the United States whose
438.22 standards for credentialing are determined by the ~~commissioner~~ board to be equivalent to
438.23 or exceed the requirements for licensure under section 148.6410 may be eligible for licensure
438.24 by reciprocity as an occupational therapy assistant. Nothing in this section limits the
438.25 ~~commissioner's~~ board's authority to deny licensure based upon the grounds for discipline
438.26 in sections 148.6401 to 148.6450. An applicant must provide:

438.27 (1) the application materials as required by section 148.6420, subdivisions 1, 3, and 4;

438.28 (2) the fees required by section 148.6445;

438.29 (3) a copy of a current and unrestricted credential for the practice of occupational therapy
438.30 as either an occupational therapist or occupational therapy assistant;

438.31 (4) a letter from the jurisdiction that issued the credential describing the applicant's
438.32 qualifications that entitled the applicant to receive the credential; and

439.1 (5) other information necessary to determine whether the credentialing standards of the
439.2 jurisdiction that issued the credential are equivalent to or exceed the requirements for
439.3 licensure under sections 148.6401 to 148.6450.

439.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

439.5 Sec. 13. Minnesota Statutes 2016, section 148.6418, subdivision 1, is amended to read:

439.6 Subdivision 1. **Application.** The ~~commissioner~~ board shall issue temporary licensure
439.7 as an occupational therapist or occupational therapy assistant to applicants who are not the
439.8 subject of a disciplinary action or past disciplinary action, nor disqualified on the basis of
439.9 items listed in section 148.6448, subdivision 1.

439.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

439.11 Sec. 14. Minnesota Statutes 2016, section 148.6418, subdivision 2, is amended to read:

439.12 Subd. 2. **Procedures.** To be eligible for temporary licensure, an applicant must submit
439.13 a completed application for temporary licensure on forms provided by the ~~commissioner~~
439.14 board, the fees required by section 148.6445, and one of the following:

439.15 (1) evidence of successful completion of the requirements in section 148.6408,
439.16 subdivision 1, or 148.6410, subdivision 1;

439.17 (2) a copy of a current and unrestricted credential for the practice of occupational therapy
439.18 as either an occupational therapist or occupational therapy assistant in another jurisdiction;
439.19 or

439.20 (3) a copy of a current and unrestricted certificate from the National Board for
439.21 Certification in Occupational Therapy stating that the applicant is certified as an occupational
439.22 therapist or occupational therapy assistant.

439.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

439.24 Sec. 15. Minnesota Statutes 2016, section 148.6418, subdivision 4, is amended to read:

439.25 Subd. 4. **Supervision required.** An applicant who has graduated from an accredited
439.26 occupational therapy program, as required by section 148.6408, subdivision 1, or 148.6410,
439.27 subdivision 1, and who has not passed the examination required by section 148.6408,
439.28 subdivision 2, or 148.6410, subdivision 2, must practice under the supervision of a licensed
439.29 occupational therapist. The supervising therapist must, at a minimum, supervise the person
439.30 working under temporary licensure in the performance of the initial evaluation, determination
439.31 of the appropriate treatment plan, and periodic review and modification of the treatment

440.1 plan. The supervising therapist must observe the person working under temporary licensure
440.2 in order to assure service competency in carrying out evaluation, treatment planning, and
440.3 treatment implementation. The frequency of face-to-face collaboration between the person
440.4 working under temporary licensure and the supervising therapist must be based on the
440.5 condition of each patient or client, the complexity of treatment and evaluation procedures,
440.6 and the proficiencies of the person practicing under temporary licensure. The occupational
440.7 therapist or occupational therapy assistant working under temporary licensure must provide
440.8 verification of supervision on the application form provided by the ~~commissioner~~ board.

440.9 **EFFECTIVE DATE.** This section is effective January 1, 2018.

440.10 Sec. 16. Minnesota Statutes 2016, section 148.6418, subdivision 5, is amended to read:

440.11 Subd. 5. **Expiration of temporary licensure.** A temporary license issued to a person
440.12 pursuant to subdivision 2, clause (1), expires six months from the date of issuance for
440.13 occupational therapists and occupational therapy assistants or on the date the ~~commissioner~~
440.14 board grants or denies licensure, whichever occurs first. A temporary license issued to a
440.15 person pursuant to subdivision 2, clause (2) or (3), expires 90 days after it is issued. Upon
440.16 application for renewal, a temporary license shall be renewed once to persons who have
440.17 not met the examination requirement under section 148.6408, subdivision 2, or 148.6410,
440.18 subdivision 2, within the initial temporary licensure period and who are not the subject of
440.19 a disciplinary action nor disqualified on the basis of items in section 148.6448, subdivision
440.20 1. Upon application for renewal, a temporary license shall be renewed once to persons who
440.21 are able to demonstrate good cause for failure to meet the requirements for licensure under
440.22 section 148.6412 or 148.6415 within the initial temporary licensure period and who are not
440.23 the subject of a disciplinary action nor disqualified on the basis of items in section 148.6448,
440.24 subdivision 1.

440.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

440.26 Sec. 17. Minnesota Statutes 2016, section 148.6420, subdivision 1, is amended to read:

440.27 Subdivision 1. **Applications for licensure.** An applicant for licensure must:

440.28 (1) submit a completed application for licensure on forms provided by the ~~commissioner~~
440.29 board and must supply the information requested on the application, including:

440.30 (i) the applicant's name, business address and business telephone number, business
440.31 setting, and daytime telephone number;

440.32 (ii) the name and location of the occupational therapy program the applicant completed;

441.1 (iii) a description of the applicant's education and training, including a list of degrees
441.2 received from educational institutions;

441.3 (iv) the applicant's work history for the six years preceding the application, including
441.4 the number of hours worked;

441.5 (v) a list of all credentials currently and previously held in Minnesota and other
441.6 jurisdictions;

441.7 (vi) a description of any jurisdiction's refusal to credential the applicant;

441.8 (vii) a description of all professional disciplinary actions initiated against the applicant
441.9 in any jurisdiction;

441.10 (viii) information on any physical or mental condition or chemical dependency that
441.11 impairs the person's ability to engage in the practice of occupational therapy with reasonable
441.12 judgment or safety;

441.13 (ix) a description of any misdemeanor or felony conviction that relates to honesty or to
441.14 the practice of occupational therapy;

441.15 (x) a description of any state or federal court order, including a conciliation court
441.16 judgment or a disciplinary order, related to the individual's occupational therapy practice;
441.17 and

441.18 (xi) a statement indicating the physical agent modalities the applicant will use and
441.19 whether the applicant will use the modalities as an occupational therapist or an occupational
441.20 therapy assistant under direct supervision;

441.21 (2) submit with the application all fees required by section 148.6445;

441.22 (3) sign a statement that the information in the application is true and correct to the best
441.23 of the applicant's knowledge and belief;

441.24 (4) sign a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's
441.25 records in this or any other state in which the applicant holds or previously held a credential
441.26 for the practice of an occupation, has completed an accredited occupational therapy education
441.27 program, or engaged in the practice of occupational therapy;

441.28 (5) submit additional information as requested by the ~~commissioner~~ board; and

441.29 (6) submit the additional information required for licensure by equivalency, licensure
441.30 by reciprocity, and temporary licensure as specified in sections 148.6408 to 148.6418.

441.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

442.1 Sec. 18. Minnesota Statutes 2016, section 148.6420, subdivision 3, is amended to read:

442.2 Subd. 3. **Applicants certified by National Board for Certification in Occupational**
 442.3 **Therapy.** An applicant who is certified by the National Board for Certification in
 442.4 Occupational Therapy must provide the materials required in subdivision 1 and the following:

442.5 (1) verified documentation from the National Board for Certification in Occupational
 442.6 Therapy stating that the applicant is certified as an occupational therapist, registered or
 442.7 certified occupational therapy assistant, the date certification was granted, and the applicant's
 442.8 certification number. The document must also include a statement regarding disciplinary
 442.9 actions. The applicant is responsible for obtaining this documentation by sending a form
 442.10 provided by the ~~commissioner~~ board to the National Board for Certification in Occupational
 442.11 Therapy; and

442.12 (2) a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's
 442.13 records maintained by the National Board for Certification in Occupational Therapy.

442.14 **EFFECTIVE DATE.** This section is effective January 1, 2018.

442.15 Sec. 19. Minnesota Statutes 2016, section 148.6420, subdivision 5, is amended to read:

442.16 Subd. 5. **Action on applications for licensure.** (a) The ~~commissioner~~ board shall
 442.17 approve, approve with conditions, or deny licensure. The ~~commissioner~~ board shall act on
 442.18 an application for licensure according to paragraphs (b) to (d).

442.19 (b) The ~~commissioner~~ board shall determine if the applicant meets the requirements for
 442.20 licensure. The ~~commissioner~~ board, or the advisory council at the ~~commissioner's~~ board's
 442.21 request, may investigate information provided by an applicant to determine whether the
 442.22 information is accurate and complete.

442.23 (c) The ~~commissioner~~ board shall notify an applicant of action taken on the application
 442.24 and, if licensure is denied or approved with conditions, the grounds for the ~~commissioner's~~
 442.25 board's determination.

442.26 (d) An applicant denied licensure or granted licensure with conditions may make a
 442.27 written request to the ~~commissioner~~ board, within 30 days of the date of the ~~commissioner's~~
 442.28 board's determination, for reconsideration of the ~~commissioner's~~ board's determination.
 442.29 Individuals requesting reconsideration may submit information which the applicant wants
 442.30 considered in the reconsideration. After reconsideration of the ~~commissioner's~~ board's
 442.31 determination to deny licensure or grant licensure with conditions, the ~~commissioner~~ board
 442.32 shall determine whether the original determination should be affirmed or modified. An
 442.33 applicant is allowed no more than one request in any one biennial licensure period for

443.1 reconsideration of the ~~commissioner's~~ board's determination to deny licensure or approve
443.2 licensure with conditions.

443.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

443.4 Sec. 20. Minnesota Statutes 2016, section 148.6423, is amended to read:

443.5 **148.6423 LICENSURE RENEWAL.**

443.6 Subdivision 1. **Renewal requirements.** To be eligible for licensure renewal, a licensee
443.7 must:

443.8 (1) submit a completed and signed application for licensure renewal on forms provided
443.9 by the ~~commissioner~~ board;

443.10 (2) submit the renewal fee required under section 148.6445;

443.11 (3) submit proof of having met the continuing education requirement of section 148.6443
443.12 on forms provided by the ~~commissioner~~ board; and

443.13 (4) submit additional information as requested by the ~~commissioner~~ board to clarify
443.14 information presented in the renewal application. The information must be submitted within
443.15 30 days after the ~~commissioner's~~ board's request.

443.16 Subd. 2. **Renewal deadline.** (a) Except as provided in paragraph (c), licenses must be
443.17 renewed every two years. Licensees must comply with the following procedures in paragraphs
443.18 (b) to (e):

443.19 (b) Each license must state an expiration date. An application for licensure renewal must
443.20 be received by the ~~Department of Health~~ board or postmarked at least 30 calendar days
443.21 before the expiration date. If the postmark is illegible, the application shall be considered
443.22 timely if received at least 21 calendar days before the expiration date.

443.23 (c) If the ~~commissioner~~ board changes the renewal schedule and the expiration date is
443.24 less than two years, the fee and the continuing education contact hours to be reported at the
443.25 next renewal must be prorated.

443.26 (d) An application for licensure renewal not received within the time required under
443.27 paragraph (b), but received on or before the expiration date, must be accompanied by a late
443.28 fee in addition to the renewal fee specified by section 148.6445.

443.29 (e) Licensure renewals received after the expiration date shall not be accepted and persons
443.30 seeking licensed status must comply with the requirements of section 148.6425.

444.1 Subd. 3. **Licensure renewal notice.** At least 60 calendar days before the expiration date
444.2 in subdivision 2, the ~~commissioner~~ board shall mail a renewal notice to the licensee's last
444.3 known address on file with the ~~commissioner~~ board. The notice must include an application
444.4 for licensure renewal and notice of fees required for renewal. The licensee's failure to receive
444.5 notice does not relieve the licensee of the obligation to meet the renewal deadline and other
444.6 requirements for licensure renewal.

444.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

444.8 Sec. 21. Minnesota Statutes 2016, section 148.6425, subdivision 2, is amended to read:

444.9 Subd. 2. **Licensure renewal after licensure expiration date.** An individual whose
444.10 application for licensure renewal is received after the licensure expiration date must submit
444.11 the following:

444.12 (1) a completed and signed application for licensure following lapse in licensed status
444.13 on forms provided by the ~~commissioner~~ board;

444.14 (2) the renewal fee and the late fee required under section 148.6445;

444.15 (3) proof of having met the continuing education requirements in section 148.6443,
444.16 subdivision 1; and

444.17 (4) additional information as requested by the ~~commissioner~~ board to clarify information
444.18 in the application, including information to determine whether the individual has engaged
444.19 in conduct warranting disciplinary action as set forth in section 148.6448. The information
444.20 must be submitted within 30 days after the ~~commissioner's~~ board's request.

444.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

444.22 Sec. 22. Minnesota Statutes 2016, section 148.6425, subdivision 3, is amended to read:

444.23 Subd. 3. **Licensure renewal four years or more after licensure expiration date.** (a)
444.24 An individual who requests licensure renewal four years or more after the licensure expiration
444.25 date must submit the following:

444.26 (1) a completed and signed application for licensure on forms provided by the
444.27 ~~commissioner~~ board;

444.28 (2) the renewal fee and the late fee required under section 148.6445 if renewal application
444.29 is based on paragraph (b), clause (1), (2), or (3), or the renewal fee required under section
444.30 148.6445 if renewal application is based on paragraph (b), clause (4);

445.1 (3) proof of having met the continuing education requirement in section 148.6443,
445.2 subdivision 1, except the continuing education must be obtained in the two years immediately
445.3 preceding application renewal; and

445.4 (4) at the time of the next licensure renewal, proof of having met the continuing education
445.5 requirement, which shall be prorated based on the number of months licensed during the
445.6 two-year licensure period.

445.7 (b) In addition to the requirements in paragraph (a), the applicant must submit proof of
445.8 one of the following:

445.9 (1) verified documentation of successful completion of 160 hours of supervised practice
445.10 approved by the ~~commissioner~~ board as described in paragraph (c);

445.11 (2) verified documentation of having achieved a qualifying score on the credentialing
445.12 examination for occupational therapists or the credentialing examination for occupational
445.13 therapy assistants administered within the past year;

445.14 (3) documentation of having completed a combination of occupational therapy courses
445.15 or an occupational therapy refresher program that contains both a theoretical and clinical
445.16 component approved by the ~~commissioner~~ board. Only courses completed within one year
445.17 preceding the date of the application or one year after the date of the application qualify for
445.18 approval; or

445.19 (4) evidence that the applicant holds a current and unrestricted credential for the practice
445.20 of occupational therapy in another jurisdiction and that the applicant's credential from that
445.21 jurisdiction has been held in good standing during the period of lapse.

445.22 (c) To participate in a supervised practice as described in paragraph (b), clause (1), the
445.23 applicant shall obtain limited licensure. To apply for limited licensure, the applicant shall
445.24 submit the completed limited licensure application, fees, and agreement for supervision of
445.25 an occupational therapist or occupational therapy assistant practicing under limited licensure
445.26 signed by the supervising therapist and the applicant. The supervising occupational therapist
445.27 shall state the proposed level of supervision on the supervision agreement form provided
445.28 by the ~~commissioner~~ board. The supervising therapist shall determine the frequency and
445.29 manner of supervision based on the condition of the patient or client, the complexity of the
445.30 procedure, and the proficiencies of the supervised occupational therapist. At a minimum, a
445.31 supervising occupational therapist shall be on the premises at all times that the person
445.32 practicing under limited licensure is working; be in the room ten percent of the hours worked
445.33 each week by the person practicing under limited licensure; and provide daily face-to-face
445.34 collaboration for the purpose of observing service competency of the occupational therapist

446.1 or occupational therapy assistant, discussing treatment procedures and each client's response
446.2 to treatment, and reviewing and modifying, as necessary, each treatment plan. The supervising
446.3 therapist shall document the supervision provided. The occupational therapist participating
446.4 in a supervised practice is responsible for obtaining the supervision required under this
446.5 paragraph and must comply with the ~~commissioner's~~ board's requirements for supervision
446.6 during the entire 160 hours of supervised practice. The supervised practice must be completed
446.7 in two months and may be completed at the applicant's place of work.

446.8 (d) In addition to the requirements in paragraphs (a) and (b), the applicant must submit
446.9 additional information as requested by the ~~commissioner~~ board to clarify information in the
446.10 application, including information to determine whether the applicant has engaged in conduct
446.11 warranting disciplinary action as set forth in section 148.6448. The information must be
446.12 submitted within 30 days after the ~~commissioner's~~ board's request.

446.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

446.14 Sec. 23. Minnesota Statutes 2016, section 148.6428, is amended to read:

446.15 **148.6428 CHANGE OF NAME, ADDRESS, OR EMPLOYMENT.**

446.16 A licensee who changes a name, address, or employment must inform the ~~commissioner~~
446.17 board, in writing, of the change of name, address, employment, business address, or business
446.18 telephone number within 30 days. A change in name must be accompanied by a copy of a
446.19 marriage certificate or court order. All notices or other correspondence mailed to or served
446.20 on a licensee by the ~~commissioner~~ board at the licensee's address on file with the
446.21 ~~commissioner~~ board shall be considered as having been received by the licensee.

446.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

446.23 Sec. 24. Minnesota Statutes 2016, section 148.6443, subdivision 5, is amended to read:

446.24 Subd. 5. **Reporting continuing education contact hours.** Within one month following
446.25 licensure expiration, each licensee shall submit verification that the licensee has met the
446.26 continuing education requirements of this section on the continuing education report form
446.27 provided by the ~~commissioner~~ board. The continuing education report form may require
446.28 the following information:

446.29 (1) title of continuing education activity;

446.30 (2) brief description of the continuing education activity;

446.31 (3) sponsor, presenter, or author;

447.1 (4) location and attendance dates;

447.2 (5) number of contact hours; and

447.3 (6) licensee's notarized affirmation that the information is true and correct.

447.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

447.5 Sec. 25. Minnesota Statutes 2016, section 148.6443, subdivision 6, is amended to read:

447.6 Subd. 6. **Auditing continuing education reports.** (a) The ~~commissioner~~ board may
447.7 audit a percentage of the continuing education reports based on random selection. A licensee
447.8 shall maintain all documentation required by this section for two years after the last day of
447.9 the biennial licensure period in which the contact hours were earned.

447.10 (b) All renewal applications that are received after the expiration date may be subject
447.11 to a continuing education report audit.

447.12 (c) Any licensee against whom a complaint is filed may be subject to a continuing
447.13 education report audit.

447.14 (d) The licensee shall make the following information available to the ~~commissioner~~
447.15 board for auditing purposes:

447.16 (1) a copy of the completed continuing education report form for the continuing education
447.17 reporting period that is the subject of the audit including all supporting documentation
447.18 required by subdivision 5;

447.19 (2) a description of the continuing education activity prepared by the presenter or sponsor
447.20 that includes the course title or subject matter, date, place, number of program contact hours,
447.21 presenters, and sponsors;

447.22 (3) documentation of self-study programs by materials prepared by the presenter or
447.23 sponsor that includes the course title, course description, name of sponsor or author, and
447.24 the number of hours required to complete the program;

447.25 (4) documentation of university, college, or vocational school courses by a course
447.26 syllabus, listing in a course bulletin, or equivalent documentation that includes the course
447.27 title, instructor's name, course dates, number of contact hours, and course content, objectives,
447.28 or goals; and

447.29 (5) verification of attendance by:

448.1 (i) a signature of the presenter or a designee at the continuing education activity on the
448.2 continuing education report form or a certificate of attendance with the course name, course
448.3 date, and licensee's name;

448.4 (ii) a summary or outline of the educational content of an audio or video educational
448.5 activity to verify the licensee's participation in the activity if a designee is not available to
448.6 sign the continuing education report form;

448.7 (iii) verification of self-study programs by a certificate of completion or other
448.8 documentation indicating that the individual has demonstrated knowledge and has
448.9 successfully completed the program; or

448.10 (iv) verification of attendance at a university, college, or vocational course by an official
448.11 transcript.

448.12 **EFFECTIVE DATE.** This section is effective January 1, 2018.

448.13 Sec. 26. Minnesota Statutes 2016, section 148.6443, subdivision 7, is amended to read:

448.14 Subd. 7. **Waiver of continuing education requirements.** The ~~commissioner~~ board may
448.15 grant a waiver of the requirements of this section in cases where the requirements would
448.16 impose an extreme hardship on the licensee. The request for a waiver must be in writing,
448.17 state the circumstances that constitute extreme hardship, state the period of time the licensee
448.18 wishes to have the continuing education requirement waived, and state the alternative
448.19 measures that will be taken if a waiver is granted. The ~~commissioner~~ board shall set forth,
448.20 in writing, the reasons for granting or denying the waiver. Waivers granted by the
448.21 ~~commissioner~~ board shall specify, in writing, the time limitation and required alternative
448.22 measures to be taken by the licensee. A request for waiver shall be denied if the ~~commissioner~~
448.23 board finds that the circumstances stated by the licensee do not support a claim of extreme
448.24 hardship, the requested time period for waiver is unreasonable, the alternative measures
448.25 proposed by the licensee are not equivalent to the continuing education activity being waived,
448.26 or the request for waiver is not submitted to the ~~commissioner~~ board within 60 days after
448.27 the expiration date.

448.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

448.29 Sec. 27. Minnesota Statutes 2016, section 148.6443, subdivision 8, is amended to read:

448.30 Subd. 8. **Penalties for noncompliance.** The ~~commissioner~~ board shall refuse to renew
448.31 or grant, or shall suspend, condition, limit, or qualify the license of any person who the
448.32 ~~commissioner~~ board determines has failed to comply with the continuing education

449.1 requirements of this section. A licensee may request reconsideration of the ~~commissioner's~~
 449.2 board's determination of noncompliance or the penalty imposed under this section by making
 449.3 a written request to the ~~commissioner~~ board within 30 days of the date of notification to the
 449.4 applicant. Individuals requesting reconsideration may submit information that the licensee
 449.5 wants considered in the reconsideration.

449.6 **EFFECTIVE DATE.** This section is effective January 1, 2018.

449.7 Sec. 28. Minnesota Statutes 2016, section 148.6445, subdivision 1, is amended to read:

449.8 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists
 449.9 is \$145. The initial licensure fee for occupational therapy assistants is \$80. The ~~commissioner~~
 449.10 board shall prorate fees based on the number of quarters remaining in the biennial licensure
 449.11 period.

449.12 **EFFECTIVE DATE.** This section is effective January 1, 2018.

449.13 Sec. 29. Minnesota Statutes 2016, section 148.6445, subdivision 10, is amended to read:

449.14 Subd. 10. **Use of fees.** All fees are nonrefundable. The ~~commissioner~~ board shall only
 449.15 use fees collected under this section for the purposes of administering this chapter. The
 449.16 legislature must not transfer money generated by these fees from the state government
 449.17 special revenue fund to the general fund. ~~Surcharges collected by the commissioner of health~~
 449.18 ~~under section 16E.22 are not subject to this subdivision.~~

449.19 **EFFECTIVE DATE.** This section is effective January 1, 2018.

449.20 Sec. 30. Minnesota Statutes 2016, section 148.6448, is amended to read:

449.21 **148.6448 GROUNDS FOR DENIAL OF LICENSURE OR DISCIPLINE;**
 449.22 **INVESTIGATION PROCEDURES; DISCIPLINARY ACTIONS.**

449.23 Subdivision 1. **Grounds for denial of licensure or discipline.** The ~~commissioner~~ board
 449.24 may deny an application for licensure, may approve licensure with conditions, or may
 449.25 discipline a licensee using any disciplinary actions listed in subdivision 3 on proof that the
 449.26 individual has:

449.27 (1) intentionally submitted false or misleading information to the ~~commissioner~~ board
 449.28 or the advisory council;

449.29 (2) failed, within 30 days, to provide information in response to a written request by the
 449.30 ~~commissioner~~ board or advisory council;

- 450.1 (3) performed services of an occupational therapist or occupational therapy assistant in
450.2 an incompetent manner or in a manner that falls below the community standard of care;
- 450.3 (4) failed to satisfactorily perform occupational therapy services during a period of
450.4 temporary licensure;
- 450.5 (5) violated sections 148.6401 to 148.6450;
- 450.6 (6) failed to perform services with reasonable judgment, skill, or safety due to the use
450.7 of alcohol or drugs, or other physical or mental impairment;
- 450.8 (7) been convicted of violating any state or federal law, rule, or regulation which directly
450.9 relates to the practice of occupational therapy;
- 450.10 (8) aided or abetted another person in violating any provision of sections 148.6401 to
450.11 148.6450;
- 450.12 (9) been disciplined for conduct in the practice of an occupation by the state of Minnesota,
450.13 another jurisdiction, or a national professional association, if any of the grounds for discipline
450.14 are the same or substantially equivalent to those in sections 148.6401 to 148.6450;
- 450.15 (10) not cooperated with the ~~commissioner or advisory council~~ board in an investigation
450.16 conducted according to subdivision 2;
- 450.17 (11) advertised in a manner that is false or misleading;
- 450.18 (12) engaged in dishonest, unethical, or unprofessional conduct in connection with the
450.19 practice of occupational therapy that is likely to deceive, defraud, or harm the public;
- 450.20 (13) demonstrated a willful or careless disregard for the health, welfare, or safety of a
450.21 client;
- 450.22 (14) performed medical diagnosis or provided treatment, other than occupational therapy,
450.23 without being licensed to do so under the laws of this state;
- 450.24 (15) paid or promised to pay a commission or part of a fee to any person who contacts
450.25 the occupational therapist for consultation or sends patients to the occupational therapist
450.26 for treatment;
- 450.27 (16) engaged in an incentive payment arrangement, other than that prohibited by clause
450.28 (15), that promotes occupational therapy overutilization, whereby the referring person or
450.29 person who controls the availability of occupational therapy services to a client profits
450.30 unreasonably as a result of client treatment;

451.1 (17) engaged in abusive or fraudulent billing practices, including violations of federal
451.2 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical
451.3 assistance laws;

451.4 (18) obtained money, property, or services from a consumer through the use of undue
451.5 influence, high pressure sales tactics, harassment, duress, deception, or fraud;

451.6 (19) performed services for a client who had no possibility of benefiting from the services;

451.7 (20) failed to refer a client for medical evaluation when appropriate or when a client
451.8 indicated symptoms associated with diseases that could be medically or surgically treated;

451.9 (21) engaged in conduct with a client that is sexual or may reasonably be interpreted by
451.10 the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a
451.11 patient;

451.12 (22) violated a federal or state court order, including a conciliation court judgment, or
451.13 a disciplinary order issued by the ~~commissioner~~ board, related to the person's occupational
451.14 therapy practice; or

451.15 (23) any other just cause related to the practice of occupational therapy.

451.16 Subd. 2. **Investigation of complaints.** The ~~commissioner~~, or the advisory council when
451.17 ~~authorized by the commissioner~~, board may initiate an investigation upon receiving a
451.18 complaint or other oral or written communication that alleges or implies that a person has
451.19 violated sections 148.6401 to 148.6450. In the receipt, investigation, and hearing of a
451.20 complaint that alleges or implies a person has violated sections 148.6401 to 148.6450, the
451.21 ~~commissioner~~ board shall follow the procedures in section 214.10.

451.22 Subd. 3. **Disciplinary actions.** If the ~~commissioner~~ board finds that an occupational
451.23 therapist or occupational therapy assistant should be disciplined according to subdivision
451.24 1, the ~~commissioner~~ board may take any one or more of the following actions:

451.25 (1) refuse to grant or renew licensure;

451.26 (2) approve licensure with conditions;

451.27 (3) revoke licensure;

451.28 (4) suspend licensure;

451.29 (5) any reasonable lesser action including, but not limited to, reprimand or restriction
451.30 on licensure; or

451.31 (6) any action authorized by statute.

452.1 Subd. 4. **Effect of specific disciplinary action on use of title.** Upon notice from the
 452.2 ~~commissioner~~ board denying licensure renewal or upon notice that disciplinary actions have
 452.3 been imposed and the person is no longer entitled to practice occupational therapy and use
 452.4 the occupational therapy and licensed titles, the person shall cease to practice occupational
 452.5 therapy, to use titles protected by sections 148.6401 to 148.6450, and to represent to the
 452.6 public that the person is licensed by the ~~commissioner~~ board.

452.7 Subd. 5. **Reinstatement requirements after disciplinary action.** A person who has
 452.8 had licensure suspended may request and provide justification for reinstatement following
 452.9 the period of suspension specified by the ~~commissioner~~ board. The requirements of sections
 452.10 148.6423 and 148.6425 for renewing licensure and any other conditions imposed with the
 452.11 suspension must be met before licensure may be reinstated.

452.12 Subd. 6. **Authority to contract.** The ~~commissioner~~ board shall contract with the health
 452.13 professionals services program as authorized by sections 214.31 to 214.37 to provide these
 452.14 services to practitioners under this chapter. The health professionals services program does
 452.15 not affect the ~~commissioner's~~ board's authority to discipline violations of sections 148.6401
 452.16 to 148.6450.

452.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

452.18 Sec. 31. **[148.6449] BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

452.19 **Subdivision 1. Creation.** The Board of Occupational Therapy Practice consists of 11
 452.20 members appointed by the governor. The members are:

452.21 (1) five occupational therapists licensed under sections 148.6401 to 148.6449;

452.22 (2) three occupational therapy assistants licensed under sections 148.6401 to 148.6449;

452.23 and

452.24 (3) three public members, including two members who have received occupational
 452.25 therapy services or have a family member who has received occupational therapy services,
 452.26 and one member who is a health care professional or health care provider licensed in
 452.27 Minnesota.

452.28 **Subd. 2. Qualifications of board members.** (a) The occupational therapy practitioners
 452.29 appointed to the board must represent a variety of practice areas and settings.

452.30 (b) At least two occupational therapy practitioners must be employed outside the
 452.31 seven-county metropolitan area.

452.32 (c) Board members shall serve for not more than two consecutive terms.

453.1 Subd. 3. **Recommendations for appointment.** Prior to the end of the term of a member
453.2 of the board, or within 60 days after a position on the board becomes vacant, the Minnesota
453.3 Occupational Therapy Association and other interested persons and organizations may
453.4 recommend to the governor members qualified to serve on the board. The governor may
453.5 appoint members to the board from the list of persons recommended or from among other
453.6 qualified candidates.

453.7 Subd. 4. **Officers.** The board shall biennially elect from its membership a chair, vice-chair,
453.8 and secretary-treasurer. Each officer shall serve until a successor is elected.

453.9 Subd. 5. **Executive director.** The board shall appoint and employ an executive director
453.10 who is not a member of the board. The employment of the executive director shall be subject
453.11 to the terms described in section 214.04, subdivision 2a.

453.12 Subd. 6. **Terms; compensation; removal of members.** Membership terms, compensation
453.13 of members, removal of members, the filling of membership vacancies, and fiscal year and
453.14 reporting requirements shall be as provided in chapter 214. The provision of staff,
453.15 administrative services, and office space; the review and processing of complaints; the
453.16 setting of board fees; and other activities relating to board operations shall be conducted
453.17 according to chapter 214.

453.18 Subd. 7. **Duties of the Board of Occupational Therapy Practice.** (a) The board shall:

453.19 (1) adopt and enforce rules and laws necessary for licensing occupational therapy
453.20 practitioners;

453.21 (2) adopt and enforce rules for regulating the professional conduct of the practice of
453.22 occupational therapy;

453.23 (3) issue licenses to qualified individuals in accordance with sections 148.6401 to
453.24 148.6449;

453.25 (4) assess and collect fees for the issuance and renewal of licenses;

453.26 (5) educate the public about the requirements for licensing occupational therapy
453.27 practitioners, educate occupational therapy practitioners about the rules of conduct, and
453.28 enable the public to file complaints against applicants and licensees who may have violated
453.29 sections 148.6401 to 148.6449; and

453.30 (6) investigate individuals engaging in practices that violate sections 148.6401 to
453.31 148.6449 and take necessary disciplinary, corrective, or other action according to section
453.32 148.6448.

454.1 (b) The board may adopt rules necessary to define standards or carry out the provisions
454.2 of sections 148.6401 to 148.6449. Rules shall be adopted according to chapter 14.

454.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

454.4 Sec. 32. Minnesota Statutes 2016, section 214.01, subdivision 2, is amended to read:

454.5 Subd. 2. **Health-related licensing board.** "Health-related licensing board" means the
454.6 Board of Examiners of Nursing Home Administrators established pursuant to section
454.7 144A.19, the Office of Unlicensed Complementary and Alternative Health Care Practice
454.8 established pursuant to section 146A.02, the Board of Medical Practice created pursuant to
454.9 section 147.01, the Board of Nursing created pursuant to section 148.181, the Board of
454.10 Chiropractic Examiners established pursuant to section 148.02, the Board of Optometry
454.11 established pursuant to section 148.52, the Board of Occupational Therapy Practice
454.12 established pursuant to section 148.6449, the Board of Physical Therapy established pursuant
454.13 to section 148.67, the Board of Psychology established pursuant to section 148.90, the Board
454.14 of Social Work pursuant to section 148E.025, the Board of Marriage and Family Therapy
454.15 pursuant to section 148B.30, the Board of Behavioral Health and Therapy established by
454.16 section 148B.51, the Board of Dietetics and Nutrition Practice established under section
454.17 148.622, the Board of Dentistry established pursuant to section 150A.02, the Board of
454.18 Pharmacy established pursuant to section 151.02, the Board of Podiatric Medicine established
454.19 pursuant to section 153.02, and the Board of Veterinary Medicine established pursuant to
454.20 section 156.01.

454.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

454.22 Sec. 33. **BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

454.23 The governor shall appoint all members to the Board of Occupational Therapy Practice
454.24 under Minnesota Statutes, section 148.6449, by October 1, 2017. The governor shall designate
454.25 one member of the board to convene the first meeting of the board by November 1, 2017.
454.26 The board shall elect officers at its first meeting.

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

454.28 Sec. 34. **REVISOR'S INSTRUCTION.**

454.29 In Minnesota Statutes, the revisor of statutes shall replace references to Minnesota
454.30 Statutes, section 148.6450, with Minnesota Statutes, section 148.6449.

454.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

455.1 Sec. 35. **REPEALER.**

455.2 (a) Minnesota Statutes 2016, sections 147A.21; 147B.08, subdivisions 1, 2, and 3;
 455.3 147C.40, subdivisions 1, 2, 3, and 4; 148.6402, subdivision 2; and 148.6450, are repealed.

455.4 (b) Minnesota Rules, part 5600.2500, is repealed.

455.5 **EFFECTIVE DATE.** This section is effective January 1, 2018.

455.6 **ARTICLE 12**455.7 **HUMAN SERVICES FORECAST ADJUSTMENTS**455.8 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

455.9 The dollar amounts shown are added to or, if shown in parentheses, are subtracted from
 455.10 the appropriations in Laws 2015, chapter 71, article 14, as amended by Laws 2016, chapter
 455.11 189, articles 22 and 23, from the general fund, or any other fund named, to the Department
 455.12 of Human Services for the purposes specified in this article, to be available for the fiscal
 455.13 years indicated for each purpose. The figure "2017" used in this article means that the
 455.14 appropriations listed are available for the fiscal year ending June 30, 2017.

455.15 **APPROPRIATIONS**
 455.16 **Available for the Year**
 455.17 **Ending June 30**
 455.18 **2017**

455.19 Sec. 2. **COMMISSIONER OF HUMAN**
 455.20 **SERVICES**

455.21 **Subdivision 1. Total Appropriation** **\$ (342,045,000)**

455.22 **Appropriations by Fund**

455.23 **2017**

455.24 <u>General Fund</u>	<u>(198,450,000)</u>
455.25 <u>Health Care Access</u>	<u>(146,590,000)</u>
455.26 <u>TANF</u>	<u>2,995,000</u>

455.27 **Subd. 2. Forecasted Programs**

455.28 **(a) MFIP/DWP Grants**

455.29 **Appropriations by Fund**

455.30 <u>General Fund</u>	<u>(2,111,000)</u>
455.31 <u>TANF</u>	<u>2,579,000</u>

455.32 **(b) MFIP Child Care Assistance Grants** **(6,513,000)**

456.1	<u>(c) General Assistance Grants</u>	<u>(4,219,000)</u>
456.2	<u>(d) Minnesota Supplemental Aid Grants</u>	<u>(581,000)</u>
456.3	<u>(e) Group Residential Housing Grants</u>	<u>(533,000)</u>
456.4	<u>(f) Northstar Care for Children</u>	<u>2,613,000</u>
456.5	<u>(g) MinnesotaCare Grants</u>	<u>(145,883,000)</u>
456.6	<u>This appropriation is from the health care</u>	
456.7	<u>access fund.</u>	
456.8	<u>(h) Medical Assistance Grants</u>	
456.9	<u>Appropriations by Fund</u>	
456.10	<u>General Fund</u>	<u>(192,744,000)</u>
456.11	<u>Health Care Access</u>	<u>(707,000)</u>
456.12	<u>(i) Alternative Care Grants</u>	<u>-0-</u>
456.13	<u>(j) CD Entitlement Grants</u>	<u>5,638,000</u>
456.14	<u>Subd. 3. Technical Activities</u>	<u>416,000</u>
456.15	<u>This appropriation is from the TANF fund.</u>	

456.16 Sec. 3. EFFECTIVE DATE.

456.17 Sections 1 and 2 are effective the day following final enactment.

456.18 **ARTICLE 13**

456.19 **APPROPRIATIONS**

456.20 Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

456.21 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
 456.22 and for the purposes specified in this article. The appropriations are from the general fund,
 456.23 or another named fund, and are available for the fiscal years indicated for each purpose.

456.24 The figures "2018" and "2019" used in this article mean that the appropriations listed under
 456.25 them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively.
 456.26 "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium"
 456.27 is fiscal years 2018 and 2019.

456.28 **APPROPRIATIONS**

456.29 **Available for the Year**

457.1	<u>Ending June 30</u>		
457.2	<u>2018</u>	<u>2019</u>	
457.3 457.4	<u>Sec. 2. COMMISSIONER OF HUMAN SERVICES</u>		
457.5	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 7,456,445,000</u>	<u>\$ 7,519,648,000</u>
457.6	<u>Appropriations by Fund</u>		
457.7	<u>2018</u>	<u>2019</u>	
457.8	<u>General</u>	<u>6,902,997,000</u>	<u>6,956,473,000</u>
457.9	<u>State Government</u>		
457.10	<u>Special Revenue</u>	<u>4,296,000</u>	<u>4,296,000</u>
457.11	<u>Health Care Access</u>	<u>270,320,000</u>	<u>286,281,000</u>
457.12	<u>Federal TANF</u>	<u>276,936,000</u>	<u>270,702,000</u>
457.13	<u>Lottery Prize</u>	<u>1,896,000</u>	<u>1,896,000</u>
457.14 457.15 457.16	<u>The amounts that may be spent for each purpose are specified in the following subdivisions.</u>		
457.17	<u>Subd. 2. TANF Maintenance of Effort</u>		
457.18 457.19 457.20 457.21 457.22 457.23 457.24 457.25 457.26 457.27 457.28	<u>(a) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:</u>		
457.29 457.30 457.31	<u>(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;</u>		
457.32 457.33 457.34	<u>(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative</u>		

458.1 costs under Minnesota Statutes, section
458.2 119B.15;

458.3 (3) state and county MFIP administrative costs
458.4 under Minnesota Statutes, chapters 256J and
458.5 256K;

458.6 (4) state, county, and tribal MFIP employment
458.7 services under Minnesota Statutes, chapters
458.8 256J and 256K;

458.9 (5) expenditures made on behalf of legal
458.10 noncitizen MFIP recipients who qualify for
458.11 the MinnesotaCare program under Minnesota
458.12 Statutes, chapter 256L;

458.13 (6) qualifying working family credit
458.14 expenditures under Minnesota Statutes, section
458.15 290.0671;

458.16 (7) qualifying Minnesota education credit
458.17 expenditures under Minnesota Statutes, section
458.18 290.0674; and

458.19 (8) qualifying Head Start expenditures under
458.20 Minnesota Statutes, section 119A.50.

458.21 (b) For the activities listed in paragraph (a),
458.22 clauses (2) to (8), the commissioner may
458.23 report only expenditures that are excluded
458.24 from the definition of assistance under Code
458.25 of Federal Regulations, title 45, section
458.26 260.31.

458.27 (c) The commissioner shall ensure that the
458.28 MOE used by the commissioner of
458.29 management and budget for the February and
458.30 November forecasts required under Minnesota
458.31 Statutes, section 16A.103, contains
458.32 expenditures under paragraph (a), clause (1),
458.33 equal to at least 16 percent of the total required

459.1 under Code of Federal Regulations, title 45,
459.2 section 263.1.

459.3 (d) The commissioner may not claim an
459.4 amount of TANF/MOE in excess of the 75
459.5 percent standard in Code of Federal
459.6 Regulations, title 45, section 263.1(a)(2),
459.7 except:

459.8 (1) to the extent necessary to meet the 80
459.9 percent standard under Code of Federal
459.10 Regulations, title 45, section 263.1(a)(1), if it
459.11 is determined by the commissioner that the
459.12 state will not meet the TANF work
459.13 participation target rate for the current year;

459.14 (2) to provide any additional amounts under
459.15 Code of Federal Regulations, title 45, section
459.16 264.5, that relate to replacement of TANF
459.17 funds due to the operation of TANF penalties;
459.18 and

459.19 (3) to provide any additional amounts that may
459.20 contribute to avoiding or reducing TANF work
459.21 participation penalties through the operation
459.22 of the excess MOE provisions of Code of
459.23 Federal Regulations, title 45, section 261.43
459.24 (a)(2).

459.25 (e) For the purposes of paragraph (d), the
459.26 commissioner may supplement the MOE claim
459.27 with working family credit expenditures or
459.28 other qualified expenditures to the extent such
459.29 expenditures are otherwise available after
459.30 considering the expenditures allowed in this
459.31 subdivision.

459.32 (f) The requirement in Minnesota Statutes,
459.33 section 256.011, subdivision 3, that federal
459.34 grants or aids secured or obtained under that

460.1 subdivision be used to reduce any direct
 460.2 appropriations provided by law, does not apply
 460.3 if the grants or aids are federal TANF funds.

460.4 **(g) IT Appropriations Generally. This**
 460.5 appropriation includes funds for information
 460.6 technology projects, services, and support.
 460.7 Notwithstanding Minnesota Statutes, section
 460.8 16E.0466, funding for information technology
 460.9 project costs shall be incorporated into the
 460.10 service level agreement and paid to the Office
 460.11 of MN.IT Services by the Department of
 460.12 Human Services under the rates and
 460.13 mechanism specified in that agreement.

460.14 **(h) Receipts for Systems Project.**
 460.15 Appropriations and federal receipts for
 460.16 information systems projects for MAXIS,
 460.17 PRISM, MMIS, ISDS, METS, and SSIS must
 460.18 be deposited in the state systems account
 460.19 authorized in Minnesota Statutes, section
 460.20 256.014. Money appropriated for computer
 460.21 projects approved by the commissioner of the
 460.22 Office of MN.IT Services, funded by the
 460.23 legislature, and approved by the commissioner
 460.24 of management and budget may be transferred
 460.25 from one project to another and from
 460.26 development to operations as the
 460.27 commissioner of human services considers
 460.28 necessary. Any unexpended balance in the
 460.29 appropriation for these projects does not
 460.30 cancel and is available for ongoing
 460.31 development and operations.

460.32 **Subd. 3. Central Office; Operations**

460.33 Appropriations by Fund

460.34 <u>General</u>	<u>110,687,000</u>	<u>109,242,000</u>
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461.1 State Government

461.2 Special Revenue 4,171,000 4,171,000

461.3 Health Care Access 20,025,000 20,025,000

461.4 Federal TANF 100,000 100,000

461.5 **(a) Administrative Recovery; Set-Aside. The**

461.6 **commissioner may invoice local entities**

461.7 **through the SWIFT accounting system as an**

461.8 **alternative means to recover the actual cost of**

461.9 **administering the following provisions:**

461.10 **(1) Minnesota Statutes, section 125A.744,**

461.11 **subdivision 3;**

461.12 **(2) Minnesota Statutes, section 245.495,**

461.13 **paragraph (b);**

461.14 **(3) Minnesota Statutes, section 256B.0625,**

461.15 **subdivision 20, paragraph (k);**

461.16 **(4) Minnesota Statutes, section 256B.0924,**

461.17 **subdivision 6, paragraph (g);**

461.18 **(5) Minnesota Statutes, section 256B.0945,**

461.19 **subdivision 4, paragraph (d); and**

461.20 **(6) Minnesota Statutes, section 256F.10,**

461.21 **subdivision 6, paragraph (b).**

461.22 **(b) Vulnerable Adults Complaints Case**

461.23 **Management System. \$258,000 in fiscal year**

461.24 **2018 is from the general fund for the Office**

461.25 **of Inspector General to implement a case**

461.26 **management system for tracking and**

461.27 **managing complaints and investigations**

461.28 **involving vulnerable adults. In consultation**

461.29 **with the Department of Health, Office of**

461.30 **Health Facility Complaints, the Office of**

461.31 **Inspector General shall ensure that the case**

461.32 **management system is capable of:**

461.33 **(1) uniquely tracking each complaint received**

461.34 **by the Office of Inspector General and the**

462.1 Office of Health Facility Complaints, whether
 462.2 the complaint is received through the
 462.3 Minnesota Adult Abuse Reporting Center, by
 462.4 telephone, by referral from another agency or
 462.5 division, or by any other means;

462.6 (2) linking each complaint to any and all
 462.7 investigations related to that complaint;

462.8 (3) tracking and coordinating referrals and
 462.9 communication between state agencies,
 462.10 including the Office of Ombudsman for
 462.11 Long-Term Care and the Office of
 462.12 Ombudsman for Mental Health and
 462.13 Developmental Disabilities; and

462.14 (4) securing data as required under the
 462.15 Vulnerable Adults Act and the Government
 462.16 Data Practices Act.

462.17 Products and services for the case management
 462.18 system design, implementation, and
 462.19 application hosting must be acquired using a
 462.20 request for proposals. This is a onetime
 462.21 appropriation and is available until June 30,
 462.22 2019.

462.23 **(c) Transfer to Office of Legislative Auditor.**
 462.24 \$600,000 in fiscal year 2018 and \$600,000 in
 462.25 fiscal year 2019 are for transfer to the Office
 462.26 of the Legislative Auditor for audit activities
 462.27 under Minnesota Statutes, section 3.972,
 462.28 subdivision 2b.

462.29 **(d) Base Level Adjustment.** The general fund
 462.30 base is \$107,551,000 in fiscal year 2020 and
 462.31 \$107,411,000 in fiscal year 2021.

462.32 **Subd. 4. Central Office; Children and Families**

462.33	<u>Appropriations by Fund</u>		
462.34	<u>General</u>	<u>8,938,000</u>	<u>8,694,000</u>

464.1 (c) **Base Level Adjustment.** The general fund
 464.2 base is \$27,577,000 in fiscal year 2020 and
 464.3 \$27,810,000 in fiscal year 2021.

464.4 Subd. 6. **Central Office; Continuing Care for**
 464.5 **Older Adults**

464.6	<u>Appropriations by Fund</u>		
464.7	<u>General</u>	<u>14,240,000</u>	<u>14,021,000</u>
464.8	<u>State Government</u>		
464.9	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

464.10 **Base Level Adjustment.** The general fund
 464.11 base is \$14,071,000 in fiscal year 2020 and
 464.12 \$14,071,000 in fiscal year 2021.

464.13 Subd. 7. **Central Office; Community Supports**

464.14	<u>Appropriations by Fund</u>		
464.15	<u>General</u>	<u>25,377,000</u>	<u>25,398,000</u>
464.16	<u>Lottery Prize</u>	<u>163,000</u>	<u>163,000</u>

464.17 (a) **Transportation Study.** \$250,000 in fiscal
 464.18 year 2018 and \$250,000 in fiscal year 2019
 464.19 are for the transportation study required under
 464.20 article 1, section 43. This is a onetime
 464.21 appropriation.

464.22 (b) **Deaf and Hard-of-Hearing Services.** (a)
 464.23 \$850,000 in fiscal year 2018 and \$700,000 in
 464.24 fiscal year 2019 are from the general fund for
 464.25 the Deaf and Hard-of-Hearing Division under
 464.26 Minnesota Statutes, section 256C.233.
 464.27 \$150,000 of this appropriation must be used
 464.28 for technology improvements, technology
 464.29 support, and training for staff on the use of
 464.30 technology for external facing services to
 464.31 implement Minnesota Statutes, section
 464.32 256C.24, subdivision 2, clause (12).

464.33 (c) **Substance Use Disorder System Study.**
 464.34 \$150,000 in fiscal year 2018 and \$150,000 in
 464.35 fiscal year 2019 are for a substance use

465.1 disorder system study. This is a onetime
 465.2 appropriation.

465.3 **(d) Base Level Adjustment.** The general fund
 465.4 base is \$24,937,000 in fiscal year 2020 and
 465.5 \$24,820,000 in fiscal year 2021.

465.6 **Subd. 8. Forecasted Programs; MFIP/DWP**

465.7 Appropriations by Fund

465.8 General 88,530,000 97,912,000

465.9 Federal TANF 94,617,000 88,230,000

465.10 **Subd. 9. Forecasted Programs; MFIP Child Care**
 465.11 **Assistance**

107,340,000

101,675,000

465.12 **Subd. 10. Forecasted Programs; General**
 465.13 **Assistance**

55,536,000

57,221,000

465.14 **(a) General Assistance Standard.** The
 465.15 commissioner shall set the monthly standard
 465.16 of assistance for general assistance units
 465.17 consisting of an adult recipient who is
 465.18 childless and unmarried or living apart from
 465.19 parents or a legal guardian at \$203. The
 465.20 commissioner may reduce this amount
 465.21 according to Laws 1997, chapter 85, article 3,
 465.22 section 54.

465.23 **(b) Emergency General Assistance Limit.**

465.24 The amount appropriated for emergency
 465.25 general assistance is limited to no more than
 465.26 \$6,729,812 in fiscal year 2018 and \$6,729,812
 465.27 in fiscal year 2019. Funds to counties shall be
 465.28 allocated by the commissioner using the
 465.29 allocation method under Minnesota Statutes,
 465.30 section 256D.06.

465.31 **Subd. 11. Forecasted Programs; Minnesota**
 465.32 **Supplemental Aid**

40,484,000

41,634,000

465.33 **Subd. 12. Forecasted Programs; Group**
 465.34 **Residential Housing**

170,337,000

180,668,000

465.35 **Subd. 13. Forecasted Programs; Northstar Care**
 465.36 **for Children**

80,542,000

96,433,000

- 466.1 Subd. 14. Forecasted Programs; MinnesotaCare 12,224,000 13,308,000
- 466.2 This appropriation is from the health care
- 466.3 access fund.
- 466.4 Subd. 15. Forecasted Programs; Medical
- 466.5 Assistance
- 466.6 Appropriations by Fund
- | | | |
|---------------------------------|----------------------|----------------------|
| 466.7 <u>General</u> | <u>5,312,619,000</u> | <u>5,316,032,000</u> |
| 466.8 <u>Health Care Access</u> | <u>210,159,000</u> | <u>224,929,000</u> |
- 466.9 (a) Behavioral Health Services. \$1,000,000
- 466.10 in fiscal year 2018 and \$1,000,000 in fiscal
- 466.11 year 2019 are for behavioral health services
- 466.12 provided by hospitals identified under
- 466.13 Minnesota Statutes, section 256.969,
- 466.14 subdivision 2b, paragraph (a), clause (4). The
- 466.15 increase in payments shall be made by
- 466.16 increasing the adjustment under Minnesota
- 466.17 Statutes, section 256.969, subdivision 2b,
- 466.18 paragraph (e), clause (2).
- 466.19 (b) Reform of MnCHOICES
- 466.20 Administration.The commissioner of human
- 466.21 services shall reduce expenditures for
- 466.22 MnCHOICES by \$30,753,000 in fiscal year
- 466.23 2018 and \$30,753,000 in fiscal year 2019. To
- 466.24 accomplish this reduction in expenditures, the
- 466.25 commissioner shall permit lead agencies as
- 466.26 defined in Minnesota Statutes, section
- 466.27 256B.0911, subdivision 1a, paragraph (e), to
- 466.28 substitute to the greatest extent permitted
- 466.29 under federal law, service updates under
- 466.30 Minnesota Statutes, section 256B.0911,
- 466.31 subdivision 3f, for reassessments required
- 466.32 under Minnesota Statutes, sections 256B.0659,
- 466.33 256B.0911, 256B.0915, 256B.092, 256B.49,
- 466.34 and 256B.85, when there is not a significant
- 466.35 change in the recipient's condition or need.

467.1	<u>Subd. 16. Forecasted Programs; Alternative</u>		
467.2	<u>Care</u>		<u>44,686,000</u> <u>45,660,000</u>
467.3	<u>Alternative Care Transfer.</u> Any money		
467.4	<u>allocated to the alternative care program that</u>		
467.5	<u>is not spent for the purposes indicated does</u>		
467.6	<u>not cancel but must be transferred to the</u>		
467.7	<u>medical assistance account.</u>		
467.8	<u>Subd. 17. Forecasted Programs; Chemical</u>		
467.9	<u>Dependency Treatment Fund</u>	<u>116,213,000</u>	<u>135,079,000</u>
467.10	<u>Subd. 18. Grant Programs; Support Services</u>		
467.11	<u>Grants</u>		
467.12	<u>Appropriations by Fund</u>		
467.13	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
467.14	<u>Federal TANF</u>	<u>93,311,000</u>	<u>93,311,000</u>
467.15	<u>Subd. 19. Grant Programs; Basic Sliding Fee</u>		
467.16	<u>Child Care Assistance Grants</u>	<u>51,932,000</u>	<u>48,034,000</u>
467.17	<u>Base Level Adjustment.</u> The general fund		
467.18	<u>base is \$48,008,000 in fiscal year 2020 and</u>		
467.19	<u>\$47,991,000 in fiscal year 2021.</u>		
467.20	<u>Subd. 20. Grant Programs; Child Care</u>		
467.21	<u>Development Grants</u>	<u>1,737,000</u>	<u>1,737,000</u>
467.22	<u>Subd. 21. Grant Programs; Child Support</u>		
467.23	<u>Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
467.24	<u>Subd. 22. Grant Programs; Children's Services</u>		
467.25	<u>Grants</u>		
467.26	<u>Appropriations by Fund</u>		
467.27	<u>General</u>	<u>40,340,000</u>	<u>39,465,000</u>
467.28	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>
467.29	<u>(a) Title IV-E Adoption Assistance.</u> (1) The		
467.30	<u>commissioner shall allocate funds from the</u>		
467.31	<u>Title IV-E reimbursement to the state from</u>		
467.32	<u>the Fostering Connections to Success and</u>		
467.33	<u>Increasing Adoptions Act for adoptive, foster,</u>		
467.34	<u>and kinship families as required in Minnesota</u>		
467.35	<u>Statutes, section 265N.621.</u>		

468.1 (2) Additional federal reimbursement to the
468.2 state as a result of the Fostering Connections
468.3 to Success and Increasing Adoptions Act's
468.4 expanded eligibility for title IV-E adoption
468.5 assistance is appropriated to the commissioner
468.6 for foster care, adoption, and kinship services,
468.7 including a parent-to-parent support network.

468.8 **(b) Adoption Assistance Incentive Grants.**

468.9 (1) The commissioner shall allocate federal
468.10 funds available for adoption and guardianship
468.11 assistance incentive grants for postadoption
468.12 services to support adoptive, foster, and
468.13 kinship families as required in Minnesota
468.14 Statutes, section 256N.621.

468.15 (2) Federal funds available during fiscal years
468.16 2018 and 2019 for adoption incentive grants
468.17 must be used for foster care, adoption, and
468.18 kinship services, including a parent-to-parent
468.19 support network.

468.20 **(c) Adoption Support Services.** The
468.21 commissioner shall allocate 20 percent of
468.22 federal funds from Title IV-B, subpart 2, of
468.23 the Social Security Act, Promoting Safe and
468.24 Stable Families, for adoption support services
468.25 under Minnesota Statutes, section 256N.261.

468.26 **(d) American Indian Child Welfare**
468.27 **Initiative.** \$800,000 in fiscal year 2018 is for
468.28 planning efforts to expand the American
468.29 Indian Child Welfare Initiative under
468.30 Minnesota Statutes, section 256.01,
468.31 subdivision 14b. Of this amount, \$400,000 is
468.32 for a grant to the Mille Lacs Band of Ojibwe
468.33 and \$400,000 is for a grant to the Red Lake
468.34 Nation. This is a onetime appropriation.

469.1 **(e) Anoka County Family Foster Care.**
 469.2 \$75,000 in fiscal year 2018 is from the general
 469.3 fund for a grant to Anoka County to establish
 469.4 and promote family foster care recruitment
 469.5 models. The county shall use the grant funds
 469.6 for the purpose of increasing foster care
 469.7 providers through administrative
 469.8 simplification, nontraditional recruitment
 469.9 models, and family incentive options, and
 469.10 develop a strategic planning model to recruit
 469.11 family foster care providers. This is a onetime
 469.12 appropriation.

469.13 **(f) White Earth Band of Ojibwe Child**
 469.14 **Welfare Services.** \$800,000 in fiscal year
 469.15 2018 and \$800,000 in fiscal year 2019 are
 469.16 from the general fund for a grant to the White
 469.17 Earth Band of Ojibwe to deliver child welfare
 469.18 services.

469.19 **Subd. 23. Grant Programs; Children and**
 469.20 **Community Service Grants**

58,201,000

58,201,000

469.21 **Subd. 24. Grant Programs; Children and**
 469.22 **Economic Support Grants**

31,280,000

31,290,000

469.23 **(a) Minnesota Food Assistance Program.**
 469.24 Unexpended funds for the Minnesota food
 469.25 assistance program for fiscal year 2018 do not
 469.26 cancel but are available for this purpose in
 469.27 fiscal year 2019.

469.28 **(b) At-Home Infant Child Care.** \$1,000,000
 469.29 in fiscal year 2018 and \$1,000,000 in fiscal
 469.30 year 2019 are from the general fund for the
 469.31 at-home infant child care program under
 469.32 Minnesota Statutes, section 119B.035.

469.33 **(c) Community Action Grants.** \$750,000 in
 469.34 fiscal year 2018 and \$750,000 in fiscal year
 469.35 2019 are for community action grants under

- 470.1 Minnesota Statutes, sections 256E.30 to
470.2 256E.32.
- 470.3 **(d) Family Assets for Independence.**
470.4 \$250,000 in fiscal year 2018 and \$250,000 in
470.5 fiscal year 2019 are for the family assets for
470.6 independence program under Minnesota
470.7 Statutes, section 256E.35.
- 470.8 **(e) Safe Harbor for Sexually Exploited**
470.9 **Youth.** (1) \$500,000 in fiscal year 2018 and
470.10 \$500,000 in fiscal year 2019 are for
470.11 emergency shelter and transitional and
470.12 long-term housing beds for sexually exploited
470.13 youth and youth at risk of sexual exploitation.
- 470.14 (2) \$100,000 in fiscal year 2018 and \$100,000
470.15 in fiscal year 2019 are for statewide youth
470.16 outreach workers connecting sexually
470.17 exploited youth and youth at risk of sexual
470.18 exploitation with shelter and services.
- 470.19 (3) Youth 24 years of age or younger are
470.20 eligible for shelter, housing beds, and services
470.21 under this paragraph. In funding shelter,
470.22 housing beds, and outreach workers under this
470.23 paragraph, the commissioner shall emphasize
470.24 activities that promote capacity-building and
470.25 development of resources in greater
470.26 Minnesota.
- 470.27 **(f) Dakota County Child Data Tracking.**
470.28 \$200,000 in fiscal year 2018 is for the
470.29 Minnesota Birth to Eight pilot project for the
470.30 development of the information technology
470.31 solution that will track the established
470.32 developmental milestone progress of each
470.33 child participating in the pilot up to age eight.

471.1 (g) Housing Benefit Web Site. \$130,000 in
 471.2 fiscal year 2018 and \$130,000 in fiscal year
 471.3 2019 are to operate the housing benefit 101
 471.4 Web site to help people who need affordable
 471.5 housing, and supports to maintain that
 471.6 housing, understand the range of housing
 471.7 options and support services available.

471.8 (h) Base Level Adjustments. The general
 471.9 fund base is \$31,743,000 in fiscal year 2020
 471.10 and \$31,743,000 in fiscal year 2021. The
 471.11 general fund base includes \$453,000 in fiscal
 471.12 year 2020 and \$453,000 in fiscal year 2021
 471.13 for community living infrastructure grant
 471.14 allocations under Minnesota Statutes, section
 471.15 256I.09.

471.16 Subd. 25. Grant Programs; Health Care Grants

471.17	<u>Appropriations by Fund</u>		
471.18	<u>General</u>	<u>4,119,000</u>	<u>4,531,000</u>
471.19	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>

471.20 Dental Services Grants. \$820,000 in fiscal
 471.21 year 2018 is from the general fund to award
 471.22 dental services grants. The commissioner may
 471.23 award grants under this section to:

- 471.24 (1) nonprofit community clinics;
 471.25 (2) federally qualified health centers, rural
 471.26 health clinics, and public health clinics;
 471.27 (3) hospital-based dental clinics owned and
 471.28 operated by a city, county, or former state
 471.29 hospital as defined in Minnesota Statutes,
 471.30 section 62Q.19, subdivision 1, paragraph (a),
 471.31 clause (4); and
 471.32 (4) a dental clinic owned and operated by the
 471.33 University of Minnesota or the Minnesota
 471.34 State Colleges and Universities system.

472.1	<u>Grants may be used to fund costs related to</u>		
472.2	<u>maintaining, coordinating, and improving</u>		
472.3	<u>access for medical assistance and</u>		
472.4	<u>MinnesotaCare enrollees to dental care in rural</u>		
472.5	<u>Minnesota.</u>		
472.6	<u>In awarding grants, the commissioner shall</u>		
472.7	<u>consider a grant applicant's experience in</u>		
472.8	<u>delivering dental services to medical assistance</u>		
472.9	<u>and MinnesotaCare enrollees in rural</u>		
472.10	<u>communities, and the applicant's potential to</u>		
472.11	<u>successfully maintain or expand access to</u>		
472.12	<u>dental services for medical assistance and</u>		
472.13	<u>MinnesotaCare enrollees.</u>		
472.14	<u>Subd. 26. Grant Programs; Other Long-Term</u>		
472.15	<u>Care Grants</u>	<u>5,500,000</u>	<u>1,925,000</u>
472.16	<u>Home and Community-Based Incentive</u>		
472.17	<u>Pool.</u> \$4,000,000 in fiscal year 2018 is for		
472.18	<u>incentive payments under Minnesota Statutes,</u>		
472.19	<u>section 256B.0921. Of this amount,</u>		
472.20	<u>\$1,000,000 is for the purposes described in</u>		
472.21	<u>Minnesota Statutes, section 256B.0921, clause</u>		
472.22	<u>(2). This is a onetime appropriation.</u>		
472.23	<u>Subd. 27. Grant Programs; Aging and Adult</u>		
472.24	<u>Services Grants</u>	<u>30,746,000</u>	<u>32,437,000</u>
472.25	<u>Base Level Adjustments.</u> The general fund		
472.26	<u>base is \$32,811,000 in fiscal year 2020 and</u>		
472.27	<u>\$32,995,000 in fiscal year 2021. The general</u>		
472.28	<u>fund base includes \$334,000 in fiscal year</u>		
472.29	<u>2020 and \$477,000 in fiscal year 2021 for the</u>		
472.30	<u>Minnesota Board on Aging for self-directed</u>		
472.31	<u>caregiver grants under Minnesota Statutes,</u>		
472.32	<u>section 256.975, subdivision 12.</u>		
472.33	<u>Subd. 28. Grant Programs; Deaf and</u>		
472.34	<u>Hard-of-Hearing Grants</u>	<u>2,625,000</u>	<u>2,775,000</u>

- 473.1 **Expanded Services Grants.** \$750,000 in
 473.2 fiscal year 2018 and \$900,000 in fiscal year
 473.3 2019 are for deaf and hard-of-hearing grants.
 473.4 The funds must be used to provide services to
 473.5 Minnesotans who are deafblind under
 473.6 Minnesota Statutes, section 256C.261, to
 473.7 provide culturally affirmative psychiatric
 473.8 services, and to provide linguistically and
 473.9 culturally appropriate mental health services
 473.10 to children who are deaf, children who are
 473.11 deafblind, and children who are
 473.12 hard-of-hearing. Of this amount, \$103,000 in
 473.13 each year is to increase the grant to provide
 473.14 mentors who have hearing loss to parents of
 473.15 infants and children with newly identified
 473.16 hearing loss. Each year the division must
 473.17 provide funds for training in ProTactile
 473.18 American Sign Language or other
 473.19 communication systems used by people who
 473.20 are deafblind. Training shall be provided to
 473.21 persons who are deafblind and to interpreters,
 473.22 support service providers, and interveners who
 473.23 work with persons who are deafblind.
- | | | | |
|--------|---|-------------------|-------------------|
| 473.24 | <u>Subd. 29. Grant Programs; Disabilities Grants</u> | <u>21,322,000</u> | <u>21,322,000</u> |
|--------|---|-------------------|-------------------|
- 473.25 (a) **Disability Waiver Rate System**
 473.26 **Transition Grants.** \$500,000 in fiscal year
 473.27 2018 and \$500,000 in fiscal year 2019 are for
 473.28 grants to home and community-based
 473.29 disability waiver services providers that are
 473.30 projected to receive at least a ten percent
 473.31 decrease in revenues due to transition to rates
 473.32 calculated under Minnesota Statutes, section
 473.33 256B.4914, and are available until June 30,
 473.34 2021. The commissioner shall award grants
 473.35 to ensure ongoing access for individuals
 473.36 currently receiving these services and provide

474.1 stability to providers as they transition to new
 474.2 service delivery models. The general fund base
 474.3 for the grants under this paragraph is
 474.4 \$4,650,000 in fiscal year 2020 and \$4,650,000
 474.5 in fiscal year 2021.

474.6 **(b) Self-Advocacy Grants.** \$183,000 in fiscal
 474.7 year 2018 and \$183,000 in fiscal year 2019
 474.8 are for Minnesota Statutes, section 256.477.

474.9 **(c) Individual Community Living Grants.**
 474.10 To the extent funding is available, the
 474.11 commissioner may transfer funds from the
 474.12 semi-independent living services grant to new
 474.13 individual community living grants to pay for
 474.14 transitional costs and facilitate the transition
 474.15 of individuals from corporate foster care to
 474.16 community living.

474.17 **(d) Gap Analysis.** \$217,000 in fiscal year
 474.18 2018 and \$218,000 in fiscal year 2019 are for
 474.19 analysis of gaps in long-term care services
 474.20 under Minnesota Statutes, section 144A.351.

474.21 **(e) Base Level Adjustment.** The general fund
 474.22 base is \$25,472,000 in fiscal year 2020 and
 474.23 \$25,472,000 in fiscal year 2021.

474.24 **Subd. 30. Grant Programs; Adult Mental Health**
 474.25 **Grants**

	<u>Appropriations by Fund</u>	
474.27 <u>General</u>	<u>82,402,000</u>	<u>82,302,000</u>
474.28 <u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>

474.29 **(a) Mental Health Innovation Grants.**
 474.30 \$2,500,000 in fiscal year 2018 and \$2,500,000
 474.31 in fiscal year 2019 are from the general fund
 474.32 for the mental health innovation grant program
 474.33 under Minnesota Statutes, section 245.4662.

475.1 **(b) Peer-Run Respite Services in Wadena**
475.2 **County.** \$100,000 in fiscal year 2018 is from
475.3 the general fund for a grant to Wadena County
475.4 for the planning and development of a peer-run
475.5 respite center for individuals experiencing
475.6 mental health conditions or co-occurring
475.7 substance abuse disorder. This is a onetime
475.8 appropriation and is available until June 30,
475.9 2021. The grant is contingent on Wadena
475.10 County providing to the commissioner of
475.11 human services a plan to fund, operate, and
475.12 sustain the program and services after the
475.13 onetime state grant is expended. Wadena
475.14 County must outline the proposed funding
475.15 stream or mechanism, and any necessary local
475.16 funding commitment, which will ensure the
475.17 program will result in a sustainable program
475.18 without future state funding. The funding
475.19 stream may include state funding for programs
475.20 and services for which the individuals served
475.21 under this paragraph may be eligible. The
475.22 commissioner of human services, in
475.23 collaboration with Wadena County, may
475.24 explore a plan for continued funding using
475.25 existing appropriations through eligibility for
475.26 group residential housing under Minnesota
475.27 Statutes, chapter 256I.

475.28 The peer-run respite center must:

475.29 (1) admit individuals who are in need of peer
475.30 support and supportive services while
475.31 addressing an increase in symptoms or
475.32 stressors or exacerbation of their mental health
475.33 or substance abuse;

475.34 (2) admit individuals to reside at the center on
475.35 a short-term basis, no longer than five days;

476.1 (3) be operated by a nonprofit organization;
 476.2 (4) employ individuals who have personal
 476.3 experience with mental health or co-occurring
 476.4 substance abuse conditions who meet the
 476.5 qualifications of a mental health certified peer
 476.6 specialist under Minnesota Statutes, section
 476.7 256B.0615, or a recovery peer;
 476.8 (5) provide at least three but no more than six
 476.9 beds in private rooms; and
 476.10 (6) not provide clinical services.

476.11 By November 1, 2018, the commissioner of
 476.12 human services, in consultation with Wadena
 476.13 County, shall report to the committees in the
 476.14 senate and house of representatives with
 476.15 jurisdiction over mental health issues, the
 476.16 status of planning and development of the
 476.17 peer-run respite center, and the plan to
 476.18 financially support the program and services
 476.19 after the state grant is expended.

476.20 **Subd. 31. Grant Programs; Child Mental Health**
 476.21 **Grants**

21,361,000

21,426,000

476.22 **(a) Children's Mental Health Collaborative**
 476.23 **Grants.** \$600,000 in fiscal year 2018 and
 476.24 \$600,000 in fiscal year 2019 are for a grant
 476.25 for a rural multicounty demonstration project
 476.26 to assist transition-aged youth and young
 476.27 adults with emotional behavioral disturbance
 476.28 (EBD) or mental illnesses in making a
 476.29 successful transition into adulthood. This is a
 476.30 onetime appropriation.

476.31 Children's mental health collaboratives under
 476.32 Minnesota Statutes, section 245.493, are
 476.33 eligible to apply for the grant under this
 476.34 paragraph. The commissioner shall solicit

477.1 proposals and award the grant to one proposal
477.2 that best meets the requirement that a
477.3 demonstration project must:

477.4 (1) build on and streamline transition services
477.5 by identifying rural youth 15 to 25 years of
477.6 age currently in the mental health system or
477.7 with emerging mental health conditions;

477.8 (2) support youth to achieve, within the youth's
477.9 potential, personal goals in employment,
477.10 education, housing, and community life
477.11 functioning;

477.12 (3) provide individualized motivational
477.13 coaching;

477.14 (4) build on needed social supports;

477.15 (5) demonstrate how services can be enhanced
477.16 for youth to successfully navigate the
477.17 complexities associated with their unique
477.18 needs;

477.19 (6) use all available funding streams;

477.20 (7) demonstrate collaboration with the local
477.21 children's mental health collaborative in
477.22 designing and implementing the demonstration
477.23 project;

477.24 (8) evaluate the effectiveness of the project
477.25 by specifying and measuring outcomes
477.26 showing the level of progress for involved
477.27 youth; and

477.28 (9) compare differences in outcomes and costs
477.29 to youth without previous access to this
477.30 project.

477.31 By January 15, 2019, the commissioner shall
477.32 report to the legislative committees with
477.33 jurisdiction over mental health issues on the

478.1 status and outcomes of the demonstration
 478.2 project. The children's mental health
 478.3 collaborative administering the demonstration
 478.4 project shall collect and report outcome data,
 478.5 as requested by the commissioner, to support
 478.6 the development of the report.

478.7 **(b) Base Level Adjustment.** The general fund
 478.8 base is \$20,826,000 in fiscal year 2020 and
 478.9 \$20,826,000 in fiscal year 2021.

478.10 **Subd. 32. Grant Programs; Chemical**
 478.11 **Dependency Treatment Support Grants**

478.12	<u>Appropriations by Fund</u>		
478.13	<u>General</u>	<u>2,136,000</u>	<u>2,136,000</u>
478.14	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

478.15 **(a) Minnesota Transitions Charter School.**
 478.16 Notwithstanding any other law to the contrary,
 478.17 Minnesota Transitions Charter School is
 478.18 eligible to receive grants under Minnesota
 478.19 Statutes, section 254A.03, subdivision 1.

478.20 **(b) Problem Gambling.** \$225,000 in fiscal
 478.21 year 2018 and \$225,000 in fiscal year 2019
 478.22 are from the lottery prize fund for a grant to
 478.23 the state affiliate recognized by the National
 478.24 Council on Problem Gambling. The affiliate
 478.25 must provide services to increase public
 478.26 awareness of problem gambling, education,
 478.27 and training for individuals and organizations
 478.28 providing effective treatment services to
 478.29 problem gamblers and their families, and
 478.30 research related to problem gambling.

478.31 **Subd. 33. Direct Care and Treatment - Generally**

478.32 **(a) Transfer Authority.** Money appropriated
 478.33 to budget activities under subdivisions 34, 35,
 478.34 36, 37, and 38 may be transferred between
 478.35 budget activities and between years of the

479.1 biennium with the approval of the
479.2 commissioner of management and budget.

479.3 **(b) Dedicated Receipts Available.** Of the
479.4 revenue received under Minnesota Statutes,
479.5 section 246.18, subdivision 8, paragraph (a),
479.6 up to \$1,000,000 each year is available for the
479.7 purposes of Minnesota Statutes, section
479.8 246.18, subdivision 8, paragraph (b), clause
479.9 (1); and up to \$2,713,000 each year is
479.10 available for the purposes of Minnesota
479.11 Statutes, section 246.18, subdivision 8,
479.12 paragraph (b), clause (2).

479.13 **Subd. 34. Direct Care and Treatment - Mental**
479.14 **Health and Substance Abuse** 114,521,000 114,607,000

479.15 **(a) Child and Adolescent Behavioral Health**
479.16 **Services.** \$405,000 in fiscal year 2018 and
479.17 \$491,000 in fiscal year 2019 are to continue
479.18 to operate the child and adolescent behavioral
479.19 health services program under Minnesota
479.20 Statutes, section 246.014.

479.21 **(b) Base Level Adjustment.** The general fund
479.22 base is \$114,116,000 in fiscal year 2020 and
479.23 \$114,116,000 in fiscal year 2021.

479.24 **Subd. 35. Direct Care and Treatment -**
479.25 **Community-Based Services** 15,298,000 15,298,000

479.26 **Subd. 36. Direct Care and Treatment - Forensic**
479.27 **Services** 91,658,000 91,675,000

479.28 **Subd. 37. Direct Care and Treatment - Sex**
479.29 **Offender Program** 86,731,000 86,731,000

479.30 **(a) Transfer Authority.** Money appropriated
479.31 for the Minnesota sex offender program may
479.32 be transferred between fiscal years of the
479.33 biennium with the approval of the
479.34 commissioner of management and budget.

480.1 **(b) Minnesota State Industries Enterprise**480.2 **Fund.** Funds remaining in the Minnesota state480.3 industries enterprise fund on September 30,480.4 2017, shall be transferred to the Minnesota480.5 sex offender program vocational work480.6 program established under Minnesota Statutes,480.7 section 246B.05.480.8 **Subd. 38. Direct Care and Treatment -**480.9 **Operations**39,787,00039,787,000480.10 **Subd. 39. Technical Activities**86,186,00086,339,000480.11 This appropriation is from the federal TANF480.12 fund.480.13 **Base Level Adjustment.** The TANF fund480.14 base is \$86,346,000 in fiscal year 2020 and480.15 \$86,355,000 in fiscal year 2021.480.16 **Sec. 3. COMMISSIONER OF HEALTH**480.17 **Subdivision 1. Total Appropriation****\$****191,192,000****\$ 187,703,000**480.18 Appropriations by Fund480.19 2018 2019480.20 General 91,866,000 89,238,000480.21 State Government480.22 Special Revenue 52,703,000 52,429,000480.23 Health Care Access 36,066,000 35,479,000480.24 Federal TANF 10,557,000 10,557,000480.25 The amounts that may be spent for each480.26 purpose are specified in the following480.27 subdivisions.480.28 **Subd. 2. Health Improvement**480.29 Appropriations by Fund480.30 General 70,713,000 68,159,000480.31 State Government480.32 Special Revenue 6,215,000 6,182,000480.33 Health Care Access 36,066,000 35,479,000480.34 Federal TANF 10,557,000 10,557,000

- 481.1 (a) TANF Appropriations. (1) \$3,579,000
481.2 of the TANF fund each year is for home
481.3 visiting and nutritional services listed under
481.4 Minnesota Statutes, section 145.882,
481.5 subdivision 7, clauses (6) and (7). Funds must
481.6 be distributed to community health boards
481.7 according to Minnesota Statutes, section
481.8 145A.131, subdivision 1.
- 481.9 (2) \$2,000,000 of the TANF fund each year
481.10 is for decreasing racial and ethnic disparities
481.11 in infant mortality rates under Minnesota
481.12 Statutes, section 145.928, subdivision 7.
- 481.13 (3) \$4,978,000 of the TANF fund each year
481.14 is for the family home visiting grant program
481.15 according to Minnesota Statutes, section
481.16 145A.17. \$4,000,000 of the funding must be
481.17 distributed to community health boards
481.18 according to Minnesota Statutes, section
481.19 145A.131, subdivision 1. \$978,000 of the
481.20 funding must be distributed to tribal
481.21 governments according to Minnesota Statutes,
481.22 section 145A.14, subdivision 2a.
- 481.23 (4) The commissioner may use up to 6.23
481.24 percent of the funds appropriated each year to
481.25 conduct the ongoing evaluations required
481.26 under Minnesota Statutes, section 145A.17,
481.27 subdivision 7, and training and technical
481.28 assistance as required under Minnesota
481.29 Statutes, section 145A.17, subdivisions 4 and
481.30 5.
- 481.31 (b) TANF Carryforward. Any unexpended
481.32 balance of the TANF appropriation in the first
481.33 year of the biennium does not cancel but is
481.34 available for the second year.

482.1 (c) Targeted Home Visiting. \$2,000,000 in
482.2 fiscal year 2018 and \$2,000,000 in fiscal year
482.3 2019 are from the general fund to provide
482.4 start-up and expansion grants to community
482.5 health boards, nonprofit organizations, and
482.6 tribal nations to start up or expand targeted
482.7 home visiting programs. Grant funds must be
482.8 used to start up or expand nurse-family
482.9 partnership programs in the county,
482.10 reservation, or region to serve families, such
482.11 as parents with high risk or high needs, parents
482.12 with a history of mental illness, domestic
482.13 abuse, or substance abuse, or first-time
482.14 mothers prenatally by 28 weeks gestation until
482.15 the child is four years of age, who are eligible
482.16 for medical assistance under Minnesota
482.17 Statutes, chapter 256B, or the federal Special
482.18 Supplemental Nutrition Program for Women,
482.19 Infants, and Children. The commissioner shall
482.20 award grants to community health boards,
482.21 nonprofits, or tribal nations in metropolitan
482.22 and rural areas of the state. Priority for grants
482.23 to rural areas shall be given to community
482.24 health boards, nonprofits, and tribal nations
482.25 that expand services within regional
482.26 partnerships that provide the nurse-family
482.27 partnership program or other quality targeted
482.28 home visiting programs. This funding shall
482.29 only be used to supplement, not to replace,
482.30 funds being used for nurse-family partnership
482.31 home visiting services as of June 30, 2017.

482.32 (d) Safe Harbor for Sexually Exploited
482.33 Youth Services. \$325,000 in fiscal year 2018
482.34 and \$325,000 in fiscal year 2019 are from the
482.35 general fund for trauma-informed, culturally
482.36 specific services for sexually exploited youth.

483.1 Youth 24 years of age or younger are eligible
483.2 for services under this paragraph.

483.3 **(e) Safe Harbor Program. \$225,000 in fiscal**
483.4 **year 2018 and \$225,000 in fiscal year 2019**
483.5 **are from the general fund for training,**
483.6 **technical assistance, protocol implementation,**
483.7 **and evaluation activities related to the safe**
483.8 **harbor program. Of these amounts:**

483.9 **(1) \$100,000 each fiscal year is for providing**
483.10 **training and technical assistance to individuals**
483.11 **and organizations that provide safe harbor**
483.12 **services and receive funds for that purpose**
483.13 **from the commissioner of human services or**
483.14 **commissioner of health;**

483.15 **(2) \$100,000 each fiscal year is for protocol**
483.16 **implementation, which includes providing**
483.17 **technical assistance in establishing best**
483.18 **practices-based systems for effectively**
483.19 **identifying, interacting with, and referring**
483.20 **sexually exploited youth to appropriate**
483.21 **resources; and**

483.22 **(3) \$25,000 each fiscal year is for program**
483.23 **evaluation activities in compliance with**
483.24 **Minnesota Statutes, section 145.4718.**

483.25 **(f) Promoting Safe Harbor Capacity. In**
483.26 **funding services and activities under**
483.27 **paragraphs (d) and (e), the commissioner shall**
483.28 **emphasize activities that promote**
483.29 **capacity-building and development of**
483.30 **resources in greater Minnesota.**

483.31 **(g) Statewide Strategic Plan for Victims of**
483.32 **Sex Trafficking. \$75,000 in fiscal year 2018**
483.33 **is from the general fund for the development**
483.34 **of a comprehensive statewide strategic plan**

484.1 and report to address the needs of sex
 484.2 trafficking victims statewide.

484.3 **(h) Comprehensive Advanced Life Support**
 484.4 **Educational Program. \$100,000 in fiscal**
 484.5 **year 2018 and \$100,000 in fiscal year 2019**
 484.6 **are from the general fund for the**
 484.7 **comprehensive advanced life support**
 484.8 **educational program under Minnesota Statutes,**
 484.9 **section 144.6062.**

484.10 **(i) Legislative Health Care Workforce**
 484.11 **Commission. \$130,000 in fiscal year 2018**
 484.12 **and \$130,000 in fiscal year 2019 are from the**
 484.13 **general fund for the Legislative Health Care**
 484.14 **Workforce Commission in Laws 2014, chapter**
 484.15 **312, article 23, section 9. The commissioner**
 484.16 **may transfer part of this appropriation to the**
 484.17 **Legislative Coordinating Commission to**
 484.18 **provide per diem and expense reimbursements**
 484.19 **to the Legislative Health Care Workforce**
 484.20 **Commission members.**

484.21 **(j) Base Level Adjustments. The general fund**
 484.22 **base is \$68,112,000 in fiscal year 2020 and**
 484.23 **\$68,159,000 in fiscal year 2021. The health**
 484.24 **care access fund base is \$36,079,000 in fiscal**
 484.25 **year 2020 and \$35,479,000 in fiscal year 2021.**

484.26 **Subd. 3. Health Protection**

484.27	<u>Appropriations by Fund</u>		
484.28	<u>General</u>	<u>13,578,000</u>	<u>13,504,000</u>
484.29	<u>State Government</u>		
484.30	<u>Special Revenue</u>	<u>46,488,000</u>	<u>46,247,000</u>

484.31 **(a) Vulnerable Adults in Health Care**
 484.32 **Settings. \$633,000 in fiscal year 2018 and**
 484.33 **\$559,000 in fiscal year 2019 are added to the**
 484.34 **appropriation from the general fund for**
 484.35 **regulating health care and home care settings.**

485.1 (b) Base Level Adjustments. The general
 485.2 fund base is \$13,893,000 in fiscal year 2020
 485.3 and \$13,803,000 in fiscal year 2021. The state
 485.4 government special revenue fund base is
 485.5 \$46,188,000 in fiscal year 2020 and
 485.6 \$46,180,000 in fiscal year 2021.

485.7 Subd. 4. Health Operations 7,575,000 7,575,000

485.8 Sec. 4. HEALTH-RELATED BOARDS

485.9 Subdivision 1. Total Appropriation \$ 21,543,000 \$ 21,073,000

485.10 This appropriation is from the state
 485.11 government special revenue fund. The
 485.12 amounts that may be spent for each purpose
 485.13 are specified in the following subdivisions.

485.14 Subd. 2. Board of Chiropractic Examiners 542,000 542,000

485.15 Base Level Adjustment. The base is \$547,000
 485.16 in fiscal year 2020 and \$547,000 in fiscal year
 485.17 2021.

485.18 Subd. 3. Board of Dentistry 1,366,000 1,366,000

485.19 Subd. 4. Board of Dietetics and Nutrition
 485.20 Practice 122,000 122,000

485.21 Subd. 5. Board of Marriage and Family Therapy 296,000 296,000

485.22 Base Level Adjustment. The base is \$297,000
 485.23 in fiscal year 2020 and \$297,000 in fiscal year
 485.24 2021.

485.25 Subd. 6. Board of Medical Practice 4,890,000 4,999,000

485.26 This appropriation includes \$955,000 in fiscal
 485.27 year 2018 and \$964,000 in fiscal year 2019
 485.28 for the health professional services program.
 485.29 The base for this program is \$924,000 in fiscal
 485.30 year 2020 and \$924,000 in fiscal year 2021.

485.31 Base Level Adjustment. The base is
 485.32 \$4,961,000 in fiscal year 2020 and \$4,961,000
 485.33 in fiscal year 2021.

486.1	<u>Subd. 7. Board of Nursing</u>	<u>4,790,000</u>	<u>4,190,000</u>
486.2	<u>Subd. 8. Board of Nursing Home Administrators</u>	<u>2,731,000</u>	<u>2,752,000</u>
486.3	<u>(a) Administrative Services Unit - Operating</u>		
486.4	<u>Costs. Of this appropriation, \$1,594,000 in</u>		
486.5	<u>fiscal year 2018 and \$1,837,000 in fiscal year</u>		
486.6	<u>2019 are for operating costs of the</u>		
486.7	<u>administrative services unit. The</u>		
486.8	<u>administrative services unit may receive and</u>		
486.9	<u>expend reimbursements for services it</u>		
486.10	<u>performs for other agencies.</u>		
486.11	<u>(b) Administrative Services Unit - Volunteer</u>		
486.12	<u>Health Care Provider Program. Of this</u>		
486.13	<u>appropriation, \$150,000 in fiscal year 2018</u>		
486.14	<u>and \$150,000 in fiscal year 2019 are to pay</u>		
486.15	<u>for medical professional liability coverage</u>		
486.16	<u>required under Minnesota Statutes, section</u>		
486.17	<u>214.40.</u>		
486.18	<u>(c) Administrative Services Unit - Contested</u>		
486.19	<u>Cases and Other Legal Proceedings. Of this</u>		
486.20	<u>appropriation, \$200,000 in fiscal year 2018</u>		
486.21	<u>and \$200,000 in fiscal year 2019 are for costs</u>		
486.22	<u>of contested case hearings and other</u>		
486.23	<u>unanticipated costs of legal proceedings</u>		
486.24	<u>involving health-related boards funded under</u>		
486.25	<u>this section. Upon certification by a</u>		
486.26	<u>health-related board to the administrative</u>		
486.27	<u>services unit that costs will be incurred and</u>		
486.28	<u>that there is insufficient money available to</u>		
486.29	<u>pay for the costs out of money currently</u>		
486.30	<u>available to that board, the administrative</u>		
486.31	<u>services unit is authorized to transfer money</u>		
486.32	<u>from this appropriation to the board for</u>		
486.33	<u>payment of those costs with the approval of</u>		
486.34	<u>the commissioner of management and budget.</u>		
486.35	<u>The commissioner of management and budget</u>		

487.1	<u>must require any board that has an unexpended</u>		
487.2	<u>balance for an amount transferred under this</u>		
487.3	<u>paragraph to transfer the unexpended amount</u>		
487.4	<u>to the administrative services unit to be</u>		
487.5	<u>deposited in the state government special</u>		
487.6	<u>revenue fund.</u>		
487.7	<u>Subd. 9. Board of Optometry</u>	<u>167,000</u>	<u>167,000</u>
487.8	<u>Subd. 10. Board of Pharmacy</u>	<u>3,069,000</u>	<u>3,069,000</u>
487.9	<u>Subd. 11. Board of Physical Therapy</u>	<u>456,000</u>	<u>456,000</u>
487.10	<u>Base Level Adjustment.</u> The base is \$457,000		
487.11	<u>in fiscal year 2020 and \$458,000 in fiscal year</u>		
487.12	<u>2021.</u>		
487.13	<u>Subd. 12. Board of Podiatric Medicine</u>	<u>204,000</u>	<u>204,000</u>
487.14	<u>Subd. 13. Board of Psychology</u>	<u>999,000</u>	<u>999,000</u>
487.15	<u>Subd. 14. Board of Social Work</u>	<u>1,122,000</u>	<u>1,122,000</u>
487.16	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>275,000</u>	<u>275,000</u>
487.17	<u>Subd. 16. Board of Behavioral Health and</u>		
487.18	<u>Therapy</u>	<u>514,000</u>	<u>514,000</u>
487.19	<u>Subd. 17. Board of Occupational Therapy</u>		
487.20	<u>Practice</u>	<u>374,000</u>	<u>328,000</u>
487.21	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
487.22	<u>REGULATORY BOARD</u>	<u>\$ 3,702,000</u>	<u>\$ 3,702,000</u>
487.23	<u>(a) Cooper/Sams Volunteer Ambulance</u>		
487.24	<u>Program.</u> \$950,000 in fiscal year 2018 and		
487.25	<u>\$950,000 in fiscal year 2019 are for the</u>		
487.26	<u>Cooper/Sams volunteer ambulance program</u>		
487.27	<u>under Minnesota Statutes, section 144E.40.</u>		
487.28	<u>Of these amounts:</u>		
487.29	<u>(1)\$861,000 in fiscal year 2018 and \$861,000</u>		
487.30	<u>in fiscal year 2019 are for the ambulance</u>		
487.31	<u>service personnel longevity award and</u>		
487.32	<u>incentive program under Minnesota Statutes,</u>		
487.33	<u>section 144E.40; and</u>		

489.1 Subdivision 1. **Total Appropriation** \$ **19,973,000** \$ **19,617,000**

489.2 Appropriations by Fund

489.3		2010	2011
489.4	General	19,723,000	19,617,000
489.5	Special Revenue		
489.6	Fund	250,000	0

489.7 The amounts that may be spent for each
 489.8 purpose are specified in the following
 489.9 subdivisions.

489.10 Subd. 2. **Government and Citizen Services** 18,097,000 17,766,000

489.11 Appropriations by Fund

489.12	General	17,847,000	17,766,000
489.13	Special Revenue		
489.14	Fund	250,000	0

489.15 (a) \$802,000 the first year and \$802,000 the
 489.16 second year are for the Minnesota Geospatial
 489.17 Information Office. Of the total appropriation,
 489.18 \$10,000 per year is intended for preparation
 489.19 of township acreage data in Laws 2008,
 489.20 chapter 366, article 17, section 7, subdivision
 489.21 3.

489.22 (b) \$74,000 the first year and \$74,000 the
 489.23 second year are for the Council on
 489.24 Developmental Disabilities.

489.25 ~~(c) \$127,000 the first year and \$127,000 the~~
 489.26 ~~second year are for transfer to the~~
 489.27 ~~commissioner of human services for a grant~~
 489.28 ~~to the Council on Developmental Disabilities~~
 489.29 ~~for the purpose of establishing a statewide~~
 489.30 ~~self-advocacy network for persons with~~
 489.31 ~~intellectual and developmental disabilities~~
 489.32 ~~(ID/DD). The self-advocacy network shall:~~
 489.33 ~~(1) ensure that persons with ID/DD are~~
 489.34 ~~informed of their rights in employment,~~
 489.35 ~~housing, transportation, voting, government~~

490.1 ~~policy, and other issues pertinent to the ID/DD~~
490.2 ~~community; (2) provide public education and~~
490.3 ~~awareness of the civil and human rights issues~~
490.4 ~~persons with ID/DD face; (3) provide funds;~~
490.5 ~~technical assistance, and other resources for~~
490.6 ~~self-advocacy groups across the state; and (4)~~
490.7 ~~organize systems of communications to~~
490.8 ~~facilitate an exchange of information between~~
490.9 ~~self-advocacy groups. This appropriation must~~
490.10 ~~be included in the base budget for the~~
490.11 ~~commissioner of human services for the~~
490.12 ~~biennium beginning July 1, 2011.~~

490.13 (d) \$250,000 the first year and \$170,000 the
490.14 second year are to fund activities to prepare
490.15 for and promote the 2010 census.

490.16 (e) \$206,000 the first year and \$206,000 the
490.17 second year are for the Office of the State
490.18 Archaeologist.

490.19 (f) \$8,388,000 the first year and \$8,388,000
490.20 the second year are for office space costs of
490.21 the legislature and veterans organizations, for
490.22 ceremonial space, and for statutorily free
490.23 space.

490.24 (g) \$3,500,000 of the balance in the facilities
490.25 repair and replacement account in the special
490.26 revenue fund is canceled to the general fund
490.27 on July 1, 2009. This is a onetime cancellation.

490.28 (h) The requirements imposed on the
490.29 commissioner of finance and the commissioner
490.30 of administration under Laws 2007, chapter
490.31 148, article 1, section 12, subdivision 2,
490.32 paragraph (b), relating to the savings
490.33 attributable to the real property portfolio
490.34 management system are inoperative.

491.1 (i) \$250,000 is appropriated to the
 491.2 commissioner of administration from the
 491.3 information and telecommunications account
 491.4 in the special revenue fund to continue
 491.5 planning for data center consolidation,
 491.6 including beginning a predesign study and
 491.7 lifecycle cost analysis, and exploring
 491.8 technologies to reduce energy consumption
 491.9 and operating costs.

491.10 Subd. 3. Administrative Management Support	1,876,000	1,851,000
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491.11 \$125,000 each year is for the Office of Grant
 491.12 Management. During the biennium ending
 491.13 June 30, 2011, the commissioner must recover
 491.14 this amount through deductions in state grants
 491.15 subject to the jurisdiction of the office. The
 491.16 commissioner may not deduct more than 2.5
 491.17 percent from the amount of any grant. The
 491.18 amount deducted from appropriations for these
 491.19 grants must be deposited in the general fund.

491.20 \$25,000 the first year is for the Office of
 491.21 Grants Management to study and make
 491.22 recommendations on improving collaborative
 491.23 activities between the state, nonprofit entities,
 491.24 and the private sector, including: (1)
 491.25 recommendations for expanding successful
 491.26 initiatives involving not-for-profit
 491.27 organizations that have demonstrated
 491.28 measurable, positive results in addressing
 491.29 high-priority community issues; and (2)
 491.30 recommendations on grant requirements and
 491.31 design to encourage programs receiving grants
 491.32 to become self-sufficient. The office may
 491.33 appoint an advisory group to assist in the study
 491.34 and recommendations. The office must report

492.1 its recommendations to the legislature by
492.2 January 15, 2010.

492.3 Sec. 10. Laws 2012, chapter 247, article 6, section 2, subdivision 2, is amended to read:

492.4 Subd. 2. **Central Office Operations**

492.5 **(a) Operations** 118,000 356,000

492.6 **Base Level Adjustment.** The general fund
492.7 base is increased by \$91,000 in fiscal year
492.8 2014 and \$44,000 in fiscal year 2015.

492.9 **(b) Health Care** 24,000 346,000

492.10 This is a onetime appropriation.

492.11 **Managed Care Audit Activities.** In fiscal
492.12 year 2014, ~~and in each even-numbered year~~
492.13 ~~thereafter~~, the commissioner shall transfer
492.14 from the health care access fund \$1,740,000
492.15 to the legislative auditor for managed care
492.16 audit services under Minnesota Statutes,
492.17 section 256B.69, subdivision 9d. This is a
492.18 biennial appropriation. The health care access
492.19 fund base is increased by \$1,842,000 in fiscal
492.20 year 2014. ~~Notwithstanding any contrary~~
492.21 ~~provision in this article, this paragraph does~~
492.22 ~~not expire.~~

492.23 **(c) Continuing Care** 19,000 375,000

492.24 **Base Level Adjustment.** The general fund
492.25 base is decreased by \$159,000 in fiscal years
492.26 2014 and 2015.

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

492.28 Sec. 11. Laws 2013, chapter 108, article 15, section 2, subdivision 2, is amended to read:

492.29 Subd. 2. **Central Office**

492.30 The amounts that may be spent from this
492.31 appropriation for each purpose are as follows:

492.32 **(a) Operations** 2,909,000 8,957,000

493.1 **Base Adjustment.** The general fund base is
 493.2 decreased by \$8,916,000 in fiscal year 2016
 493.3 and \$8,916,000 in fiscal year 2017.

493.4	(b) Children and Families	109,000	206,000
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493.5	(c) Continuing Care	2,849,000	3,574,000
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493.6 **Base Adjustment.** The general fund base is
 493.7 decreased by \$2,000 in fiscal year 2016 and
 493.8 by \$27,000 in fiscal year 2017.

493.9	(d) Group Residential Housing	(1,166,000)	(8,602,000)
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493.10	(e) Medical Assistance	(3,950,000)	(6,420,000)
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493.11	(f) Alternative Care	(7,386,000)	(6,851,000)
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493.12	(g) Child and Community Service Grants	3,000,000	3,000,000
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493.13	(h) Aging and Adult Services Grants	5,365,000	5,936,000
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493.14 ~~**Gaps Analysis.** In fiscal year 2014, and in~~
 493.15 ~~each even-numbered year thereafter, \$435,000~~
 493.16 ~~is appropriated to conduct an analysis of gaps~~
 493.17 ~~in long-term care services under Minnesota~~
 493.18 ~~Statutes, section 144A.351. This is a biennial~~
 493.19 ~~appropriation. The base is increased by~~
 493.20 ~~\$435,000 in fiscal year 2016. Notwithstanding~~
 493.21 ~~any contrary provisions in this article, this~~
 493.22 ~~provision does not expire.~~

493.23 **Base Adjustment.** The general fund base is
 493.24 increased by \$498,000 in fiscal year 2016, and
 493.25 decreased by \$124,000 in fiscal year 2017.

493.26	(i) Disabilities Grants	414,000	414,000
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493.27 Sec. 12. TRANSFERS.

493.28 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the
 493.29 commissioner of management and budget, may transfer unencumbered appropriation balances
 493.30 for the biennium ending June 30, 2019, within fiscal years among the MFIP, general
 493.31 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
 493.32 Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing

494.1 programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
494.2 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
494.3 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
494.4 and ranking minority members of the senate Health and Human Services Finance Division
494.5 and the house of representatives Health and Human Services Finance Committee quarterly
494.6 about transfers made under this subdivision.

494.7 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money
494.8 may be transferred within the Departments of Health and Human Services as the
494.9 commissioners consider necessary, with the advance approval of the commissioner of
494.10 management and budget. The commissioner shall inform the chairs and ranking minority
494.11 members of the senate Health and Human Services Finance Division and the house of
494.12 representatives Health and Human Services Finance Committee quarterly about transfers
494.13 made under this subdivision.

494.14 Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

494.15 The commissioners of health and human services shall not use indirect cost allocations
494.16 to pay for the operational costs of any program for which they are responsible.

494.17 Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

494.18 All uncodified language contained in this article expires on June 30, 2019, unless a
494.19 different expiration date is explicit.

494.20 Sec. 15. **EFFECTIVE DATE.**

494.21 This article is effective July 1, 2017, unless a different effective date is specified.

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Article locations in S0800-1

ARTICLE 1	COMMUNITY SUPPORTS	Page.Ln 3.1
ARTICLE 2	HOUSING	Page.Ln 65.14
ARTICLE 3	CONTINUING CARE	Page.Ln 115.23
ARTICLE 4	HEALTH CARE	Page.Ln 156.7
ARTICLE 5	HEALTH INSURANCE	Page.Ln 206.18
ARTICLE 6	DIRECT CARE AND TREATMENT	Page.Ln 225.29
ARTICLE 7	CHILDREN AND FAMILIES	Page.Ln 227.24
ARTICLE 8	CHEMICAL AND MENTAL HEALTH SERVICES	Page.Ln 266.20
ARTICLE 9	OPERATIONS	Page.Ln 346.7
ARTICLE 10	HEALTH DEPARTMENT	Page.Ln 355.4
ARTICLE 11	HEALTH LICENSING BOARDS	Page.Ln 429.13
ARTICLE 12	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 455.6
ARTICLE 13	APPROPRIATIONS	Page.Ln 456.18

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.

147A.21 RULEMAKING AUTHORITY.

The board shall adopt rules:

- (1) setting license fees;
- (2) setting renewal fees;
- (3) setting fees for temporary licenses; and
- (4) establishing renewal dates.

147B.08 FEES.

Subdivision 1. **Annual registration fee.** The board shall establish the fee of \$150 for initial licensure and \$150 annual licensure renewal. The board may prorate the initial licensure fee.

Subd. 2. **Penalty fee for late renewals.** The penalty fee for late submission for renewal application is \$50.

Subd. 3. **Deposit.** Fees collected by the board under this section must be deposited in the state government special revenue fund.

147C.40 FEES.

Subdivision 1. **Fees.** The board shall adopt rules setting:

- (1) licensure fees;
- (2) renewal fees;
- (3) late fees;
- (4) inactive status fees; and
- (5) fees for temporary permits.

Subd. 2. **Proration of fees.** The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal.

Subd. 3. **Penalty fee for late renewals.** An application for license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

148.6402 DEFINITIONS.

Subd. 2. **Advisory council.** "Advisory council" means the Occupational Therapy Practitioners Advisory Council in section 148.6450.

148.6450 OCCUPATIONAL THERAPY PRACTITIONERS ADVISORY COUNCIL.

Subdivision 1. **Membership.** The commissioner shall appoint seven persons to an Occupational Therapy Practitioners Advisory Council consisting of the following:

(1) two public members, as defined in section 214.02. The public members shall be either persons who have received occupational therapy services or family members of or caregivers to such persons;

(2) two members who are occupational therapists and two occupational therapy assistants licensed under sections 148.6401 to 148.6450, each of whom is employed in a different practice area including, but not limited to, long-term care, school therapy, early intervention, administration, gerontology, industrial rehabilitation, cardiac rehabilitation, physical disability, pediatrics, mental health, home health, and hand therapy. Three of the four occupational therapy practitioners who serve on the advisory council must be currently, and for the three years preceding the appointment, engaged in the practice of occupational therapy or employed as an administrator

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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.

245A.1915 OPIOID ADDICTION TREATMENT EDUCATION REQUIREMENT FOR PROVIDERS LICENSED TO PROVIDE CHEMICAL DEPENDENCY TREATMENT SERVICES.

All programs serving persons with substance use issues licensed by the commissioner must provide educational information concerning: treatment options for opioid addiction, including the use of a medication for the use of opioid addiction; and recognition of and response to opioid overdose and the use and administration of naloxone, to clients identified as having or seeking treatment for opioid addiction. The commissioner shall develop educational materials that are supported by research and updated periodically that must be used by programs to comply with this requirement.

245A.192 PROVIDERS LICENSED TO PROVIDE TREATMENT OF OPIOID ADDICTION.

Subdivision 1. **Scope.** (a) This section applies to services licensed under this chapter to provide treatment for opioid addiction. In addition to the requirements under Minnesota Rules, parts 9530.6405 to 9530.6505, a program licensed to provide treatment of opioid addiction must meet the requirements in this section.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule, the standards of this section apply.

(c) When federal guidance or interpretations have been issued on federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.

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

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from its intended use.

(c) "Guest dose or dosing" means the practice of administering a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid addiction" means a medication approved by the Food and Drug Administration for the treatment of opioid addiction.

(f) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under Minnesota Rules, part 9530.6500.

(g) "Program" means an entity that is licensed under Minnesota Rules, part 9530.6500.

(h) "Unsupervised use" means the use of a medication for the treatment of opioid addiction dispensed for use by a client outside of the program setting. This is also referred to as a "take-home" dose.

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(i) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(j) "Minnesota health care programs" has the meaning given in section 256B.0636.

Subd. 3. **Medication orders.** Prior to the program administering or dispensing a medication used for the treatment of opioid addiction:

(1) a client-specific order must be received from an appropriately credentialed physician who is enrolled as a Minnesota health care programs provider and meets all applicable provider standards;

(2) the signed order must be documented in the client's record; and

(3) if the physician that issued the order is not able to sign the order when issued, the unsigned order must be entered in the client record at the time it was received, and the physician must review the documentation and sign the order in the client's record within 72 hours of the medication being ordered. The license holder must report to the commissioner any medication error that endangers a patient's health, as determined by the medical director.

Subd. 3a. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 5, paragraph (a), clause (1), that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing physician. The meeting must occur before the administering or dispensing of the increased dose.

Subd. 4. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. These tests must be reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

Subd. 5. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid addiction to the illicit market, any such medications dispensed to patients for unsupervised use shall be subject to the following requirements:

(1) any patient in an opioid treatment program may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and state and federal holidays; and

(2) treatment program decisions on dispensing medications used to treat opioid addiction to patients for unsupervised use beyond that set forth in clause (1) shall be determined by the medical director.

(b) A physician with authority to prescribe must consider the criteria in this subdivision in determining whether a client may be permitted unsupervised or take-home use of such medications. The criteria must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to increase or to extend the amount of time between visits to the program. The criteria include:

(1) absence of recent abuse of drugs including but not limited to opioids, nonnarcotics, and alcohol;

(2) regularity of program attendance;

(3) absence of serious behavioral problems at the program;

(4) absence of known recent criminal activity such as drug dealing;

(5) stability of the client's home environment and social relationships;

(6) length of time in comprehensive maintenance treatment;

(7) reasonable assurance that take-home medication will be safely stored within the client's home; and

(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.

(c) The determination, including the basis of the determination, must be consistent with the criteria in this subdivision and must be documented in the client's medical record.

Subd. 6. **Restrictions for unsupervised or take-home use of methadone hydrochloride.**

(a) In cases where it is determined that a client meets the criteria in subdivision 5 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in paragraphs (b) to (g) must be followed when the medication to be dispensed is methadone hydrochloride.

(b) During the first 90 days of treatment, the take-home supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the take-home supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the take-home supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day supply of take-home medication.

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(f) After one year of continuous treatment, a client may be given a maximum two-week supply of take-home medication.

(g) After two years of continuous treatment, a client may be given a maximum one-month supply of take-home medication, but must make monthly visits.

Subd. 7. Restriction exceptions. When a license holder has reason to accelerate the number of unsupervised or take-home doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use in subdivision 5, and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor for compliance with these federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 8. Guest dosing. In order to receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. Guest dosing may also occur when the client's primary clinic is not open and the client is not receiving take-home doses.

Subd. 9. Data and reporting. The license holder must submit data concerning medication used for the treatment of opioid addiction to a central registry. The data must be submitted in a method determined by the commissioner and must be submitted for each client at the time of admission and discharge. The program must document the date the information was submitted. This requirement is effective upon implementation of changes to the Drug and Alcohol Abuse Normative Evaluation System (DAANES) or development of an electronic system by which to submit the data.

Subd. 10. Nonmedication treatment services; documentation. (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in Minnesota Rules, part 9530.6430, subpart 1, item A, subitem (1), per week, for the first ten weeks following admission, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in Minnesota Rules, part 9530.6422, the assessment must be completed within 21 days of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in Minnesota Rules, part 9530.6425:

(1) treatment plan contents for maintenance clients are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for clients in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress no less than one time monthly, recorded in the six dimensions or when clinical need warrants more frequent notations; and

(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client has needs that warrant more frequent revisions or documentation.

Subd. 11. Prescription monitoring program. (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program for each client. The policy and procedure must include how the program will meet the requirements in paragraph (b).

(b) If a medication used for the treatment of opioid addiction is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, clients must be notified in writing that the commissioner of human services and the medical director will monitor the prescription monitoring program to review the prescribed controlled drugs the clients have received;

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(2) the medical director or the medical director's delegate must review the data from the Minnesota Board of Pharmacy prescription monitoring program (PMP) established under section 152.126 prior to the client being ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client file;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician's review of the data and subsequent actions must be documented in the client's individual file within 72 hours and must contain the medical director's determination of whether or not the prescriptions place the client at risk of harm and the actions to be taken in response to the PMP findings. In addition, the provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek consent for the other prescriber to disclose to the opioid treatment program's medical director the client's condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director must document whether or not changes to the client's medication dose or number of take-home doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system through which the commissioner shall routinely access the data from the Minnesota Board of Pharmacy prescription monitoring program established under section 152.126 for the purpose of determining whether any client enrolled in an opioid addiction treatment program licensed according to this section has also been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), prior to implementing this subdivision.

Subd. 12. Policies and procedures. (a) License holders must develop and maintain the policies and procedures required in this subdivision.

(b) For programs that are not open every day of the year, the license holder must maintain a policy and procedure that permits clients to receive a single unsupervised use of medication used for the treatment of opioid addiction for days that the program is closed for business, including, but not limited to, Sundays and state and federal holidays as required under subdivision 5, paragraph (a), clause (1).

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of medication used for the treatment of opioid addiction being diverted from its intended treatment use. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for carrying out diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication used for the treatment of opioid addiction, excluding those approved solely under subdivision 5, paragraph (a), clause (1), to require them to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid addiction treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the individual client's record.

(d) Medications used for the treatment of opioid addictions must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. In addition, when an order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits such assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor for compliance with these state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing

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actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 13. **Quality improvement plan.** The license holder must develop and maintain a quality improvement process and plan. The plan must:

(1) include evaluation of the services provided to clients with the goal of identifying issues that may improve service delivery and client outcomes;

(2) include goals for the program to accomplish based on the evaluation;

(3) be reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) be updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identify two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid addiction being inappropriately used by clients, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, with the goal of increasing coordination of services and identification of areas of concern to be addressed in the plan.

Subd. 14. **Placing authorities.** Programs must provide certain notification and client-specific updates to placing authorities for clients who are enrolled in Minnesota health care programs. At the request of the placing authority, the program must provide client-specific updates, including but not limited to informing the placing authority of positive drug screenings and changes in medications used for the treatment of opioid addiction ordered for the client.

Subd. 15. **A program's duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document its compliance with the requirement in paragraph (a) in either a client's record or an incident report.

(d) Failure to comply with the duty in paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

Subd. 16. **Variance.** The commissioner may grant a variance to the requirements of this section.

254A.02 DEFINITIONS.

Subd. 4. **Drug abuse or abuse of drugs.** "Drug abuse or abuse of drugs" is the use of any psychoactive or mood altering chemical substance, without compelling medical reason, in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior and which results in psychological or physiological dependency as a function of continued use.

256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency is required to submit;

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

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(3) provide a due date by which the commissioner must receive the requested information. Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under section 144A.471, subdivision 6 or 7, or currently certified for participation in Medicare as a home health agency are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

256B.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

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communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or home care nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. Within 36 hours of the end of the 120-hour transition period, an assessment may be made by the ventilator-dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

256C.23 DEFINITIONS.

Subd. 3. **Regional service center.** "Regional service center" means a facility designed to provide an entry point for deaf, deafblind, and hard-of-hearing persons of that region in need of education, employment, social, human, or other services.

256C.233 DUTIES OF STATE AGENCIES.

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

256C.25 INTERPRETER SERVICES.

Subdivision 1. **Establishment.** The Deaf and Hard-of-Hearing Services Division shall maintain and coordinate statewide interpreting or interpreter referral services for use by any public or private agency or individual in the state. The division shall directly coordinate these services but may contract with an appropriate agency to provide this service. The division may collect a \$3 fee per referral for interpreter referral services and the actual costs of interpreter services provided by department staff. Fees and payments collected shall be deposited in the general fund. The \$3 referral fee shall not be collected from state agencies or local units of government or deaf or hard-of-hearing consumers or interpreters.

Subd. 2. **Duties.** Interpreting or interpreter referral services must include:

- (1) statewide access to interpreter referral and direct interpreting services, coordinated with the regional service centers;
- (2) maintenance of a statewide directory of qualified interpreters;
- (3) assessment of the present and projected supply and demand for interpreter services statewide; and
- (4) coordination with the regional service centers on projects to train interpreters and advocate for and evaluate interpreter services.

256J.626 MFIP CONSOLIDATED FUND.

Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than \$3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner to reward high-performing counties and tribes, support promising practices, and test innovative approaches to improving outcomes for MFIP participants, family stabilization services participants, and persons at risk of receiving MFIP as detailed in subdivision 3. Project funds may be targeted to geographic areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes.

Laws 2014, chapter 312, article 23, section 9, subdivision 5

Sec. 9. **LEGISLATIVE HEALTH CARE WORKFORCE COMMISSION.**

Subd. 5. Report to the legislature. The Legislative Health Care Workforce Commission must provide a preliminary report making recommendations to the legislature by December 31, 2014. The commission must provide a final report to the legislature by December 31, 2016.

The final report must:

(1) identify current and anticipated health care workforce shortages, by both provider type and geography;

(2) evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce;

(3) study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce; and

(4) identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:

(i) training and residency shortages;

(ii) disparities in income between primary care and other providers; and

(iii) negative perceptions of primary care among students.

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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.

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.

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Subp. 2. **Adolescent.** "Adolescent" means an individual under 18 years of age.

9530.6405 DEFINITIONS.

Subp. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in Minnesota Statutes, section 148C.01, subdivision 2.

9530.6405 DEFINITIONS.

Subp. 4. **Applicant.** "Applicant" means an individual, corporation, partnership, voluntary association, controlling individual, or other organization that has applied for licensure under this chapter.

9530.6405 DEFINITIONS.

Subp. 5. **Capacity management system.** "Capacity management system" means a database operated by the Department of Human Services to compile and make information available to the public about the waiting list status and current admission capability of each program serving intravenous drug abusers.

9530.6405 DEFINITIONS.

Subp. 6. **Central registry.** "Central registry" means a database maintained by the department that collects identifying information from two or more programs about individuals applying for maintenance treatment or detoxification treatment for addiction to opiates for the purpose of avoiding an individual's concurrent enrollment in more than one program.

9530.6405 DEFINITIONS.

Subp. 7. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as defined by Minnesota Statutes, section 152.01, subdivision 4, and other mood altering substances.

9530.6405 DEFINITIONS.

Subp. 7a. **Chemical dependency treatment.** "Chemical dependency treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of services, facilitation of services provided by other service providers, and reassessment by a qualified professional. The goal of treatment is to assist or support the client's efforts to recover from substance use disorder.

9530.6405 DEFINITIONS.

Subp. 8. **Client.** "Client" means an individual accepted by a license holder for assessment or treatment of a substance use disorder. An individual remains a client until the license holder no longer provides or plans to provide the individual with treatment services.

9530.6405 DEFINITIONS.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designee.

9530.6405 DEFINITIONS.

Subp. 10. **Co-occurring or co-occurring client.** "Co-occurring" or "co-occurring client" means a diagnosis that indicates a client suffers from a substance use disorder and a mental health problem.

9530.6405 DEFINITIONS.

Subp. 11. **Department.** "Department" means the Department of Human Services.

9530.6405 DEFINITIONS.

Subp. 12. **Direct client contact.** "Direct client contact" has the meaning given for "direct contact" in Minnesota Statutes, section 245C.02, subdivision 11.

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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

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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 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:

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- (1) a change in the Department of Health's licensure of the program;
- (2) a change in whether the license holder provides services specified in parts 9530.6485 to 9530.6505;
- (3) a change in location; or
- (4) a change in capacity if the license holder meets the requirements of part 9530.6505.

B. A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

9530.6420 INITIAL SERVICES PLAN.

The license holder must complete an initial services plan during or immediately following the intake interview. The plan must address the client's immediate health and safety concerns, identify the issues to be addressed in the first treatment sessions, and make treatment suggestions for the client during the time between intake and completion of the treatment plan. The initial services plan must include a determination whether a client is a vulnerable adult as defined in Minnesota Statutes, section 626.5572, subdivision 21. All adult clients of a residential program are vulnerable adults. An individual abuse prevention plan, according to Minnesota Statutes, sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for all clients who meet the definition of "vulnerable adult."

9530.6422 COMPREHENSIVE ASSESSMENT.

Subpart 1. **Comprehensive assessment of substance use disorder.** A comprehensive assessment of the client's substance use disorder must be coordinated by an alcohol and drug counselor and completed within three calendar days after service initiation for a residential program or three sessions of the client's initiation to services for all other programs. The alcohol and drug counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate how and when it will be completed. The assessment must include sufficient information to complete the assessment summary according to subpart 2 and part 9530.6425. The comprehensive assessment must include information about the client's problems that relate to chemical use and personal strengths that support recovery, including:

- A. age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;
- B. circumstances of service initiation;
- C. previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness;
- D. chemical use history including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal;
- E. specific problem behaviors exhibited by the client when under the influence of chemicals;
- F. current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others;
- G. physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional;
- H. mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability;
- I. arrests and legal interventions related to chemical use;
- J. ability to function appropriately in work and educational settings;
- K. ability to understand written treatment materials, including rules and client rights;
- L. risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases;
- M. social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use;

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N. whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care; and

O. whether the client recognizes problems related to substance use and is willing to follow treatment recommendations.

Subp. 2. **Assessment summary.** An alcohol and drug counselor must prepare an assessment summary within three calendar days for a residential program or within three treatment sessions of service initiation. The narrative summary of the comprehensive assessment results must meet the requirements of items A and B:

A. An assessment summary must be prepared by an alcohol and drug counselor and include:

- (1) a risk description according to part 9530.6622 for each dimension listed in item B;
- (2) narrative supporting the risk descriptions; and
- (3) a determination of whether the client meets the DSM criteria for a person with a substance use disorder.

B. Contain information relevant to treatment planning and recorded in the dimensions in subitems (1) to (6):

(1) Dimension 1, acute intoxication/withdrawal potential. The license holder must consider the client's ability to cope with withdrawal symptoms and current state of intoxication.

(2) Dimension 2, biomedical conditions and complications. The license holder must consider the degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child if the client is pregnant.

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications. The license holder must determine the degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas and the likelihood of risk of harm to self or others.

(4) Dimension 4, readiness for change. The license holder must also consider the amount of support and encouragement necessary to keep the client involved in treatment.

(5) Dimension 5, relapse, continued use, and continued problem potential. The license holder must consider the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

(6) Dimension 6, recovery environment. The license holder must consider the degree to which key areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

9530.6425 INDIVIDUAL TREATMENT PLANS.

Subpart 1. **General.** Individual treatment plans for clients in treatment must be completed within seven calendar days of completion of the assessment summary. Treatment plans must continually be updated, based on new information gathered about the client's condition and on whether planned treatment interventions have had the intended effect. Treatment planning must include ongoing assessment in each of the six dimensions according to part 9530.6422, subpart 2. The plan must provide for the involvement of the client's family and those people selected by the client as being important to the success of the treatment experience at the earliest opportunity, consistent with the client's treatment needs and written consent. The plan must be developed after completion of the comprehensive assessment and is subject to amendment until services to the client are terminated. The client must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the individual treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor. The individual treatment plan may be a continuation of the initial services plan required in part 9530.6420.

Subp. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and address each problem identified in the assessment summary, and include:

A. specific methods to be used to address identified problems, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

B. resources to which the client is being referred for problems when problems are to be addressed concurrently by another provider; and

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C. goals the client must reach to complete treatment and have services terminated.

Subp. 3. Progress notes and plan review.

A. Progress notes must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff person providing the service. The note must reference the treatment plan. Progress notes must be recorded and address each of the six dimensions listed in part 9530.6422, subpart 2, item B. Progress notes must:

- (1) be entered immediately following any significant event. Significant events include those events which have an impact on the client's relationship with other clients, staff, the client's family, or the client's treatment plan;
- (2) indicate the type and amount of each treatment service the client has received;
- (3) include monitoring of any physical and mental health problems and the participation of others in the treatment plan;
- (4) document the participation of others; and
- (5) document that the client has been notified of each treatment plan change and that the client either does or does not agree with the change.

B. Treatment plan review must:

- (1) occur weekly or after each treatment service, whichever is less frequent;
- (2) address each goal in the treatment plan that has been worked on since the last review;
- (3) address whether the strategies to address the goals are effective, and if not, must include changes to the treatment plan; and
- (4) include a review and evaluation of the individual abuse prevention plan according to Minnesota Statutes, section 245A.65.

C. All entries in a client's record must be legible, signed, and dated. Late entries must be clearly labeled "late entry." Corrections to an entry must be made in a way in which the original entry can still be read.

Subp. 3a. Documentation. Progress notes and plan review do not require separate documentation if the information in the client file meets the requirements of subpart 3, items A and B.

Subp. 4. Summary at termination of services. An alcohol and drug counselor must write a discharge summary for each client. The summary must be completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier.

A. The summary at termination of services must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and include the following information:

- (1) client's problems, strengths, and needs while participating in treatment, including services provided;
- (2) client's progress toward achieving each of the goals identified in the individual treatment plan;
- (3) reasons for and circumstances of service termination; and
- (4) risk description according to part 9530.6622.

B. For clients who successfully complete treatment, the summary must also include:

- (1) living arrangements upon discharge;
- (2) continuing care recommendations, including referrals made with specific attention to continuity of care for mental health problems, as needed;
- (3) service termination diagnosis; and
- (4) client's prognosis.

9530.6430 TREATMENT SERVICES.

Subpart 1. Treatment services offered by license holder.

A. A license holder must offer the following treatment services unless clinically inappropriate and the justifying clinical rationale is documented:

- (1) individual and group counseling to help the client identify and address problems related to chemical use and develop strategies to avoid inappropriate chemical use after discharge;

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(2) client education strategies to avoid inappropriate chemical use and health problems related to chemical use and the necessary changes in lifestyle to regain and maintain health. Client education must include information concerning the human immunodeficiency virus, according to Minnesota Statutes, section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, hepatitis, and tuberculosis;

(3) transition services to help the client integrate gains made during treatment into daily living and to reduce reliance on the license holder's staff for support;

(4) services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working on recovery from substance use disorder. Groups must address co-occurring mental illness issues, as needed. When treatment for mental health problems is indicated, it is integrated into the client's treatment plan; and

(5) service coordination to help the client obtain the services and to support the client's need to establish a lifestyle free of the harmful effects of substance use disorder.

B. Treatment services provided to individual clients must be provided according to the individual treatment plan and must address cultural differences and special needs of all clients.

Subp. 2. **Additional treatment services.** A license holder may provide or arrange the following additional treatment services as a part of the individual treatment plan:

A. relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

B. therapeutic recreation to provide the client with an opportunity to participate in recreational activities without the use of mood-altering chemicals and to learn to plan and select leisure activities that do not involve the inappropriate use of chemicals;

C. stress management and physical well-being to help the client reach and maintain an acceptable level of health, physical fitness, and well-being;

D. living skills development to help the client learn basic skills necessary for independent living;

E. employment or educational services to help the client become financially independent;

F. socialization skills development to help the client live and interact with others in a positive and productive manner; and

G. room, board, and supervision provided at the treatment site to give the client a safe and appropriate environment in which to gain and practice new skills.

Subp. 3. **Counselors to provide treatment services.** Treatment services, including therapeutic recreation, must be provided by alcohol and drug counselors qualified according to part 9530.6450, unless the individual providing the service is specifically qualified according to the accepted standards of that profession. Therapeutic recreation does not include planned leisure activities.

Subp. 4. **Location of service provision.** A client of a license holder may only receive services at any of the license holder's licensed locations or at the client's home, except that services under subpart 1, item A, subitems (3) and (5), and subpart 2, items B and E, may be provided in another suitable location.

9530.6435 MEDICAL SERVICES.

Subpart 1. **Health care services description.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the license holder.

Subp. 1a. **Procedures.** The applicant or license holder must have written procedures for obtaining medical interventions when needed for a client, that are approved in writing by a physician who is licensed under Minnesota Statutes, chapter 147, unless:

A. the license holder does not provide services under part 9530.6505; and

B. all medical interventions are referred to 911, the emergency telephone number, or the client's physician.

Subp. 2. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

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Subp. 3. **Administration of medications and assistance with self-medication.** A license holder must meet the requirements in items A and B if services include medication administration.

A. A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assistance with self-medication must:

(1) document that the staff member has successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. Completion of the course must be documented in writing and placed in the staff member's personnel file; or

(2) be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder. Completion of the course must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity.

B. A registered nurse must be employed or contracted to develop the policies and procedures for medication administration or assistance with self-administration of medication or both. A registered nurse must provide supervision as defined in part 6321.0100. The registered nurse supervision must include monthly on-site supervision or more often as warranted by client health needs. The policies and procedures must include:

(1) a provision that delegations of administration of medication are limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;

(2) a provision that each client's file must include documentation indicating whether staff will be administering medication or the client will be doing self-administration or a combination of both;

(3) a provision that clients may carry emergency medication such as nitroglycerin as instructed by their physician;

(4) a provision for medication to be self-administered when a client is scheduled not to be at the facility;

(5) a provision that if medication is to be self-administered at a time when the client is present in the facility, medication will be self-administered under observation of a trained staff person;

(6) a provision that when a license holder serves clients who are parents with children, the parent may only administer medication to the child under staff supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a registered nurse of problems with self-administration, including failure to administer, client refusal of a medication, adverse reactions, or errors; and

(9) procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic.

Subp. 4. **Control of drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

A. a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

B. a system which accounts for all scheduled drugs each shift;

C. a procedure for recording the client's use of medication, including the signature of the administrator of the medication with the time and date;

D. a procedure for destruction of discontinued, outdated, or deteriorated medications;

E. a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

F. a statement that no legend drug supply for one client will be given to another client.

9530.6440 CLIENT RECORDS.

Subpart 1. **Client records required.** A license holder must maintain a file of current client records on the premises where the treatment services are provided or coordinated. The content and format of client records must be uniform and entries in each case must be signed and dated by

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the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure in compliance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164, and, if applicable, Minnesota Statutes, chapter 13.

Subp. 2. **Records retention.** Records of discharged clients must be retained by a license holder for seven years. License holders that cease to provide treatment services must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the records and the name of a person responsible for maintaining the records.

Subp. 3. **Client records, contents.** Client records must contain the following:

- A. documentation that the client was given information on client rights, responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan as required under Minnesota Statutes, section 245A.65, subdivision 2, paragraph (a), clause (4);
- B. an initial services plan completed according to part 9530.6420;
- C. a comprehensive assessment completed according to part 9530.6422;
- D. an assessment summary completed according to part 9530.6422, subpart 2;
- E. an individual abuse prevention plan that complies with Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;
- F. an individual treatment plan, as required under part 9530.6425, subparts 1 and 2;
- G. progress notes, as required in part 9530.6425, subpart 3; and
- H. a summary of termination of services, written according to part 9530.6425, subpart 4.

Subp. 4. **Electronic records.** A license holder who intends to use electronic record keeping or electronic signatures to comply with parts 9530.6405 to 9530.6505 must first obtain written permission from the commissioner. The commissioner must grant permission after the license holder provides documentation demonstrating the license holder's use of a system for ensuring security of electronic records. Use of electronic record keeping or electronic signatures does not alter the license holder's obligations under state or federal law, regulation, or rule.

9530.6445 STAFFING REQUIREMENTS.

Subpart 1. **Treatment director required.** A license holder must have a treatment director.

Subp. 2. **Alcohol and drug counselor supervisor requirements.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements under part 9530.6450, subpart 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for purposes of meeting the staffing requirements under subpart 4.

Subp. 3. **Responsible staff person.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment services. A license holder must have a designated staff person during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff person on duty 24 hours a day. The designated staff person must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 4. **Staffing requirements.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group shall not exceed an average of 16 clients during any 30 consecutive calendar days. It is the responsibility of the license holder to determine an acceptable group size based on the client's needs. A counselor in a program treating intravenous drug abusers must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subpart.

Subp. 5. **Medical emergencies.** When clients are present, a license holder must have at least one staff person on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff person on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff person with both certifications satisfies this requirement.

9530.6450 STAFF QUALIFICATIONS.

Subpart 1. **Qualifications of all staff members with direct client contact.** All staff members who have direct client contact must be at least 18 years of age. At the time of hiring, all staff members must meet the qualifications in item A or B. A chemical use problem for purposes of this subpart is a problem listed by the license holder in the personnel policies and procedures according to part 9530.6460, subpart 1, item E.

A. Treatment directors, supervisors, nurses, counselors, and other professionals must be free of chemical use problems for at least the two years immediately preceding their hiring and must sign a statement attesting to that fact.

B. Paraprofessionals and all other staff members with direct client contact must be free of chemical use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.

Subp. 2. **Employment; prohibition on chemical use problems.** Staff members with direct client contact must be free from chemical use problems as a condition of employment, but are not required to sign additional statements. Staff members with direct client contact who are not free from chemical use problems must be removed from any responsibilities that include direct client contact for the time period specified in subpart 1. The time period begins to run on the date the employee begins receiving treatment services or the date of the last incident as described in the list developed according to part 9530.6460, subpart 1, item E.

Subp. 3. **Treatment director qualifications.** In addition to meeting the requirements of subpart 1, a treatment director must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, chapter 245A, and sections 626.556, 626.557, and 626.5572. A treatment director must:

A. have at least one year of work experience in direct service to individuals with chemical use problems or one year of work experience in the management or administration of direct service to individuals with chemical use problems; and

B. have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services.

Subp. 4. **Alcohol and drug counselor supervisor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor supervisor must meet the following qualifications:

A. the individual is competent in the areas specified in subpart 5;

B. the individual has three or more years of experience providing individual and group counseling to chemically dependent clients except that, prior to January 1, 2005, an individual employed in a program formerly licensed under parts 9530.5000 to 9530.6400 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;

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(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1993. The manual is incorporated by reference. It is available at the State Law Library, Judicial Center, 25 Reverend Dr. Martin Luther King Jr. Blvd., St. Paul, Minnesota 55155;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under parts 9530.5000 to 9530.6400 and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

Subp. 6. **Paraprofessional qualifications and duties.** A paraprofessional must comply with subpart 1 and have knowledge of client rights, outlined in Minnesota Statutes, section 148F.165, and of staff responsibilities. A paraprofessional may not admit, transfer, or discharge clients but may be the person responsible for the delivery of treatment services as required in part 9530.6445, subpart 3.

Subp. 7. **Volunteers.** Volunteers may provide treatment services when they are supervised and can be seen or heard by a staff member meeting the criteria in subpart 4 or 5, but may not practice alcohol and drug counseling unless qualified under subpart 5.

Subp. 8. **Student interns.** A qualified staff person must supervise and be responsible for all treatment services performed by student interns and must review and sign all assessments, progress notes, and treatment plans prepared by the intern. Student interns must meet the requirements in subpart 1, item A, and receive the orientation and training required in part 9530.6460, subpart 1, item G, and subpart 2.

Subp. 9. **Individuals with temporary permit.** Individuals with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment services under the conditions in either item A or B.

A. The individual is supervised by a licensed alcohol and drug counselor assigned by the license holder. The licensed alcohol and drug counselor must document the amount and type of supervision at least weekly. The supervision must relate to clinical practices. One licensed alcohol and drug counselor may not supervise more than three individuals with temporary permits, according to Minnesota Statutes, section 148C.01, subdivision 12a.

B. The individual is supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of Minnesota Statutes, section 148C.044, subdivision 4.

9530.6455 PROVIDER POLICIES AND PROCEDURES.

License holders must develop a written policy and procedures manual indexed according to Minnesota Statutes, section 245A.04, subdivision 14, paragraph (c), so that staff may have immediate access to all policies and procedures and so that consumers of the services and other authorized parties may have access to all policies and procedures. The manual must contain the following materials:

A. assessment and treatment planning policies, which include screening for mental health concerns, and the inclusion of treatment objectives related to identified mental health concerns in the client's treatment plan;

B. policies and procedures regarding HIV that comply with Minnesota Statutes, section 245A.19;

C. the methods and resources used by the license holder to provide information on tuberculosis and tuberculosis screening to all clients and to report known cases of tuberculosis infection according to Minnesota Statutes, section 144.4804;

D. personnel policies that comply with part 9530.6460;

E. policies and procedures that protect client rights as required under part 9530.6470;

F. a medical services plan that complies with part 9530.6435;

G. emergency procedures that comply with part 9530.6475;

H. policies and procedures for maintaining client records under part 9530.6440;

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I. procedures for reporting the maltreatment of minors under Minnesota Statutes, section 626.556, and vulnerable adults under Minnesota Statutes, sections 245A.65, 626.557, and 626.5572;

J. a description of treatment services including the amount and type of client services provided;

K. the methods used to achieve desired client outcomes; and

L. the hours of operation and target population served.

9530.6460 PERSONNEL POLICIES AND PROCEDURES.

Subpart 1. **Policy requirements.** License holders must have written personnel policies and must make them available to each staff member. The policies must:

A. assure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the Department of Health, the Department of Human Services, the ombudsman for mental health and developmental disabilities, law enforcement, or local agencies for the investigation of complaints regarding a client's rights, health, or safety;

B. contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, and qualifications;

C. provide for job performance evaluations based on standards of job performance to be conducted on a regular and continuing basis, including a written annual review;

D. describe behavior that constitutes grounds for disciplinary action, suspension or dismissal, including policies that address chemical use problems and meet the requirements of part 9530.6450, subpart 1, policies prohibiting personal involvement with clients in violation of Minnesota Statutes, chapter 604, and policies prohibiting client abuse as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572;

E. list behaviors or incidents that are considered chemical use problems. The list must include:

(1) receiving treatment for chemical use within the period specified for the position in the staff qualification requirements;

(2) chemical use that has a negative impact on the staff member's job performance;

(3) chemical use that affects the credibility of treatment services with clients, referral sources, or other members of the community; and

(4) symptoms of intoxication or withdrawal on the job;

F. include a chart or description of the organizational structure indicating lines of authority and responsibilities;

G. include orientation within 24 working hours of starting for all new staff based on a written plan that, at a minimum, must provide for training related to the specific job functions for which the staff member was hired, policies and procedures, client confidentiality, the human immunodeficiency virus minimum standards, and client needs; and

H. policies outlining the license holder's response to staff members with behavior problems that interfere with the provision of treatment services.

Subp. 2. **Staff development.** A license holder must ensure that each staff person has the training required in items A to E.

A. All staff must be trained every two years in client confidentiality rules and regulations and client ethical boundaries.

B. All staff must be trained every two years in emergency procedures and client rights as specified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03.

C. All staff with direct client contact must be trained every year on mandatory reporting as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.5561, 626.5563, 626.557, and 626.5572, including specific training covering the facility's policies concerning obtaining client releases of information.

D. All staff with direct client contact must receive training upon hiring and annually thereafter on the human immunodeficiency virus minimum standards according to Minnesota Statutes, section 245A.19.

E. Treatment directors, supervisors, nurses, and counselors must obtain 12 hours of training in co-occurring mental health problems and substance use disorder that includes competencies related to philosophy, screening, assessment, diagnosis and treatment planning,

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documentation, programming, medication, collaboration, mental health consultation, and discharge planning. Staff employed by a license holder on the date this rule is adopted must obtain the training within 12 months of the date of adoption. New staff who have not obtained such training must obtain it within 12 months of the date this rule is adopted or within six months of hire, whichever is later. Staff may request, and the license holder may grant credit for, relevant training obtained prior to January 1, 2005.

Subp. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must be maintained to meet the requirements under parts 9530.6405 to 9530.6505 and contain the following:

A. a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

B. documentation related to the applicant's background study data, as defined in Minnesota Statutes, chapter 245C;

C. for staff members who will be providing psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry made to these former employers regarding substantiated sexual contact with a client as required by Minnesota Statutes, chapter 604;

D. documentation of completed orientation and training;

E. documentation demonstrating compliance with parts 9530.6450 and 9530.6485, subpart 2; and

F. documentation demonstrating compliance with part 9530.6435, subpart 3, for staff members who administer medications.

9530.6465 SERVICE INITIATION AND TERMINATION POLICIES.

Subpart 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences which comply with this rule and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for individuals who do not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for clients are initiated, or given to all interested persons upon request. Titles of all staff members authorized to initiate services for clients must be listed in the services initiation and termination policies. A license holder that serves intravenous drug abusers must have a written policy that provides service initiation preference as required by Code of Federal Regulations, title 45, part 96.131.

Subp. 2. **License holder responsibilities; terminating or denying services.** A license holder has specific responsibilities when terminating services or denying treatment service initiation to clients for reasons of health, behavior, or criminal activity.

A. The license holder must have and comply with a written protocol for assisting clients in need of care not provided by the license holder, and for clients who pose a substantial likelihood of harm to themselves or others, if the behavior is beyond the behavior management capabilities of the staff. All service terminations and denials of service initiation which pose an immediate threat to the health of any individual or require immediate medical intervention must be referred to a medical facility capable of admitting the individual.

B. All service termination policies and denials of service initiation that involve the commission of a crime against a license holder's staff member or on a license holder's property, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal Regulations, title 45, parts 160 to 164, must be reported to a law enforcement agency with proper jurisdiction.

Subp. 3. **Service termination and transfer policies.** A license holder must have a written policy specifying the conditions under which clients must be discharged. The policy must include:

A. procedures for individuals whose services have been terminated under subpart 2;

B. a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to clients;

C. procedures consistent with Minnesota Statutes, section 253B.16, subdivision 2, that staff must follow when a client admitted under Minnesota Statutes, chapter 253B, is to have services terminated;

D. procedures staff must follow when a client leaves against staff or medical advice and when the client may be dangerous to self or others;

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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.

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Subpart 1. **License holders serving adolescents.** A residential treatment program that serves persons under 18 years of age must be licensed as a residential program for children in out-of-home placement by the department unless the license holder is exempt under Minnesota Statutes, section 245A.03, subdivision 2.

Subp. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in part 9530.6450, subparts 1 and 5, an alcohol and drug counselor providing treatment services to adolescents must have:

A. an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

B. at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

Subp. 3. **Staffing ratios.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group consisting entirely of adolescents must not exceed 16 clients. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Subp. 4. **Academic program requirements.** Clients who are required to attend school must be enrolled and attending an educational program that has been approved by the Minnesota Department of Education.

Subp. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under part 9530.6425, programs serving adolescents must include the following:

- A. coordination with the school system to address the client's academic needs;
- B. when appropriate, a plan that addresses the client's leisure activities without chemical use; and
- C. a plan that addresses family involvement in the adolescent's treatment.

9530.6490 LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.

Subpart 1. **Health license requirements.** In addition to the requirements of parts 9530.6405 to 9530.6480, all license holders that offer supervision of children of clients are subject to the requirements of this part. License holders providing room and board for clients and their children must have an appropriate facility license from the Minnesota Department of Health.

Subp. 2. **Supervision of children defined.** "Supervision of children" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the health and safety of the child. For the school age child it means a caregiver is available to help and care for the child so that the child's health and safety is protected.

Subp. 3. **Policy and schedule required.** License holders must meet the following requirements:

A. license holders must have a policy and schedule delineating the times and circumstances under which the license holder is responsible for supervision of children in the program and when the child's parents are responsible for child supervision. The policy must explain how the program will communicate its policy about child supervision responsibility to the parents; and

B. license holders must have written procedures addressing the actions to be taken by staff if children are neglected or abused including while the children are under the supervision of their parents.

Subp. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of children, the license holder must meet the following standards:

- A. child and adult ratios in part 9502.0367;
- B. day care training in Minnesota Statutes, section 245A.50;
- C. behavior guidance in part 9502.0395;
- D. activities and equipment in part 9502.0415;
- E. physical environment in part 9502.0425; and
- F. water, food, and nutrition in part 9502.0445, unless the license holder has a license from the Minnesota Department of Health.

9530.6495 LICENSE HOLDERS SERVING PERSONS WITH SUBSTANCE USE AND MENTAL HEALTH DISORDERS.

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In addition to meeting the requirements of parts 9530.6405 to 9530.6490, license holders specializing in the treatment of persons with substance use disorder and mental health problems must:

- A. demonstrate that staffing levels are appropriate for treating clients with substance use disorder and mental health problems, and that there is adequate staff with mental health training;
- B. have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medications;
- C. have a mental health professional available for staff supervision and consultation;
- D. determine group size, structure, and content with consideration for the special needs of those with substance use disorder and mental health disorders;
- E. have documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes;
- F. have continuing documentation of collaboration with continuing care mental health providers, and involvement of those providers in treatment planning meetings;
- G. have available program materials adapted to individuals with mental health problems;
- H. have policies that provide flexibility for clients who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping clients successfully complete treatment; and
- I. have individual psychotherapy and case management available during the treatment process.

9530.6500 PROGRAMS SERVING INTRAVENOUS DRUG ABUSERS.

Subpart 1. **Additional requirements.** In addition to the requirements of parts 9530.6405 to 9530.6505, programs serving intravenous drug abusers must comply with the requirements of this part.

Subp. 2. **Capacity management and waiting list system compliance.** A program serving intravenous drug abusers must notify the department within seven days of when the program reaches both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, current enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when its census has increased or decreased from the 90 percent level.

Subp. 3. **Waiting list.** A program serving intravenous drug abusers must have a waiting list system. Each person seeking admission must be placed on the waiting list if the person cannot be admitted within 14 days of the date of application, unless the applicant is assessed by the program and found not to be eligible for admission according to parts 9530.6405 to 9530.6505, and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and Code of Federal Regulations, title 45, parts 160 to 164. The waiting list must assign a unique patient identifier for each intravenous drug abuser seeking treatment while awaiting admission. An applicant on a waiting list who receives no services under part 9530.6430, subpart 1, must not be considered a "client" as defined in part 9530.6405, subpart 8.

Subp. 4. **Client referral.** Programs serving intravenous drug abusers must consult the capacity management system so that persons on waiting lists are admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the patient has been referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subp. 5. **Outreach.** Programs serving intravenous drug abusers must carry out activities to encourage individuals in need of treatment to undergo treatment. The program's outreach model must:

- A. select, train, and supervise outreach workers;
- B. contact, communicate, and follow up with high risk substance abusers, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements, including Code of Federal Regulations, title 42, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;
- C. promote awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV; and
- D. recommend steps that can be taken to ensure that HIV transmission does not occur.

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Subp. 6. **Central registry.** Programs serving intravenous drug abusers must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The client's failure to provide the information will prohibit involvement in an opiate treatment program. The information submitted must include the client's:

- A. full name and all aliases;
- B. date of admission;
- C. date of birth;
- D. Social Security number or INS number, if any;
- E. enrollment status in other current or last known opiate treatment programs;
- F. government-issued photo-identification card number; and
- G. driver's license number, if any.

The information in items A to G must be submitted in a format prescribed by the commissioner, with the original kept in the client's chart, whenever a client is accepted for treatment, the client's type or dosage of a drug is changed, or the client's treatment is interrupted, resumed, or terminated.

9530.6505 REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.

Subpart 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to Minnesota Statutes, section 245A.02, subdivision 14, and is subject to this part.

Subp. 2. **Visitors.** Clients must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal physician, religious advisor, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided that limitations and the reasons for them are documented in the client's file. Clients must be allowed to receive visits at all reasonable times from their personal physicians, religious advisors, county case managers, parole or probation officers, and attorneys.

Subp. 3. **Client property management.** A license holder who provides room and board and treatment services to clients in the same facility, and any license holder that accepts client property must meet the requirements in Minnesota Statutes, section 245A.04, subdivision 13, for handling resident funds and property. In the course of client property management, license holders:

- A. may establish policies regarding the use of personal property to assure that treatment activities and the rights of other patients are not infringed;
- B. may take temporary custody of property for violation of facility policies;
- C. must retain the client's property for a minimum of seven days after discharge if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and
- D. must return all property held in trust to the client upon service termination regardless of the client's service termination status, except:

(1) drugs, drug paraphernalia, and drug containers that are forfeited under Minnesota Statutes, section 609.5316, must be destroyed by staff or given over to the custody of a local law enforcement agency, according to Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

(2) weapons, explosives, and other property which can cause serious harm to self or others must be given over to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the right to reclaim any lawful property transferred; and

(3) medications that have been determined by a physician to be harmful after examining the client, except when the client's personal physician approves the medication for continued use.

Subp. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

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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.