State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 1638

03/09/2015 Authored by Dean, M.,
The bill was read for the first time and referred to the Committee on Health and Human Services Finance
04/22/2015 Adoption of Report: Amended and re-referred to the Committee on Ways and Means
04/24/2015 Adoption of Report: Placed on the General Register as Amended
Read Second Time
Referred to the Chief Clerk for Comparison with S. F. No. 1458
04/25/2015 Postponed Indefinitely

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions governing health care, MinnesotaCare, MNsure, continuing care, nursing facility payments and workforce development, public health and health care delivery, children and family services, chemical and mental health, direct care and treatment, withdrawal management programs, and health-related licensing boards; establishing uniform requirements for public assistance programs related to income calculation, reporting income, and correcting overpayments and underpayments; making changes to medical assistance, home and community-based services, Northstar Care for Children, child protection, group residential housing, child support, and civil commitment; making changes to and eliminating MinnesotaCare; establishing a federally facilitated marketplace; providing for certain provider rate and grant increases; establishing the Minnesota ABLE plan and accounts; modifying requirements for administrative expenses and audits of certain public health care programs; providing for protection of born alive infants; establishing standards for withdrawal management programs; requiring reports and studies; authorizing rulemaking; making technical changes; modifying certain fees for health-related licensing boards; making human services forecast adjustments; appropriating money; amending Minnesota Statutes 2014, sections 13.46, subdivisions 2, 7; 13.461, by adding a subdivision; 15A.0815, subdivision 3; 43A.241; 62A.02, subdivision 2; 62A.045; 62Q.55, subdivision 3; 62V.02, by adding a subdivision; 62V.03, subdivision 2; 62V.04, subdivisions 1, 2, 4; 62V.05, subdivisions 1, 5, 6, by adding subdivisions; 62V.11, subdivision 2, by adding a subdivision; 103I.205, subdivision 4; 119B.011, subdivision 15; 119B.025, subdivision 1; 119B.035, subdivision 4; 119B.09, subdivision 4; 144.293, subdivision 5; 144A.071, subdivision 4a; 144A.75, subdivision 13; 144E.001, by adding a subdivision; 144E.275, subdivision 1, by adding a subdivision; 145.4131, subdivision 1; 145.423; 145.56, subdivisions 2, 4; 145.928, subdivision 13; 146B.01, subdivision 28; 146B.03, subdivisions 4, 6, by adding a subdivision; 146B.07, subdivisions 1, 2; 147.091, subdivision 1; 148.271; 148.52; 148.54; 148.57, subdivisions 1, 2, by adding a subdivision; 148.574; 148.575, subdivision 2; 148.577; 148.59; 148.603; 148E.075; 148E.080, subdivisions 1, 2; 148E.180, subdivisions 2, 5; 150A.06, subdivision 1b; 150A.091, subdivisions 4, 5, 11, by adding subdivisions; 150A.31; 151.01, subdivisions 15a, 27; 151.02; 151.065, subdivisions 1, 2, 3, 4; 151.102; 151.58, subdivisions 2, 5; 152.34; 157.15, subdivision 8; 214.077; 214.10, subdivisions 2, 2a; 214.32, subdivision 6; 245.467, subdivision 6; 245.4876, subdivision 7; 245A.06, by adding a subdivision; 245A.155, subdivisions 1, 2; 245A.65, subdivision 2; 245C.03, by

adding a subdivision; 245C.10, by adding a subdivision; 245D.02, by adding a subdivision; 245D.05, subdivisions 1, 2; 245D.06, subdivisions 1, 2, 7; 245D.07, subdivision 2; 245D.071, subdivision 5; 245D.09, subdivisions 3, 5; 245D.22, subdivision 4; 245D.31, subdivisions 3, 4, 5; 252.27, subdivision 2a; 253B.18, subdivisions 4c, 5; 256.01, by adding subdivisions; 256.017, subdivision 1; 256.478; 256.741, subdivisions 1, 2; 256.962, by adding a subdivision; 256.969, subdivisions 2b, 9; 256.975, subdivision 2, by adding a subdivision; 256.98, subdivision 1; 256B.021, subdivision 4; 256B.056, subdivision 5c; 256B.057, subdivision 9; 256B.0625, subdivisions 3b, 13, 13e, 13h, 17, 28a, 31, 58, by adding subdivisions; 256B.0631; 256B.0644; 256B.0913, subdivision 4; 256B.0915, subdivisions 3a, 3e, 3h; 256B.0916, subdivisions 2, 11, by adding a subdivision; 256B.097, subdivisions 3, 4; 256B.431, subdivisions 2b, 36; 256B.434, subdivision 4, by adding a subdivision; 256B.441, subdivisions 1, 5, 6, 13, 14, 17, 30, 31, 33, 35, 40, 44, 46c, 48, 50, 51, 51a, 53, 54, 55a, 56, 63, by adding subdivisions; 256B.49, subdivision 26, by adding a subdivision; 256B.4913, subdivisions 4a, 5; 256B.4914, subdivisions 2, 6, 8, 10, 14, 15; 256B.492; 256B.50, subdivision 1; 256B.5012, by adding a subdivision; 256B.69, subdivisions 5a, 5i, 9c, 9d, by adding a subdivision; 256B.75; 256B.76, subdivisions 1, 2; 256B.762; 256B.766; 256B.767; 256D.01, subdivision 1a; 256D.02, subdivision 8, by adding subdivisions; 256D.06, subdivision 1; 256D.405, subdivision 3; 256E.35, subdivision 2, by adding a subdivision; 256I.03, subdivisions 3, 7, by adding subdivisions; 256I.04; 256I.05, subdivisions 1c, 1g, 2; 256I.06, subdivisions 2, 6, 7, 8; 256J.08, subdivisions 26, 86; 256J.30, subdivisions 1, 9; 256J.35; 256J.40; 256J.95, subdivision 19; 256K.45, subdivision 1a; 256L.01, subdivisions 3a, 5; 256L.03, subdivision 5; 256L.04, subdivisions 1c, 7b, 10; 256L.05, subdivisions 3, 3a, 4, by adding a subdivision; 256L.06, subdivision 3; 256L.121, subdivision 1; 256N.22, subdivisions 9, 10; 256N.24, subdivision 4; 256N.25, subdivision 1; 256N.27, subdivision 2; 256P.001; 256P.01, subdivision 3, by adding subdivisions; 256P.02, by adding a subdivision; 256P.03, subdivision 1; 256P.04, subdivisions 1, 4; 256P.05, subdivision 1; 257.75, subdivisions 3, 5; 259A.75; 260C.007, subdivisions 27, 32; 260C.203; 260C.212, subdivision 1, by adding subdivisions; 260C.331, subdivision 1; 260C.451, subdivisions 2, 6; 260C.515, subdivision 5; 260C.521, subdivisions 1, 2; 260C.607, subdivision 4; 270A.03, subdivision 5; 270B.14, subdivision 1; 518A.26, subdivision 14; 518A.32, subdivision 2; 518A.39, subdivision 1, by adding a subdivision; 518A.41, subdivisions 1, 3, 4, 14, 15; 518A.43, by adding a subdivision; 518A.46, subdivision 3, by adding a subdivision; 518A.51; 518A.53, subdivision 4; 518C.802; 626.556, subdivisions 1, as amended, 2, 3, 6a, 7, as amended, 10, 10e, 11c, by adding subdivisions; Laws 2008, chapter 363, article 18, section 3, subdivision 5; Laws 2012, chapter 247, article 4, section 47, as amended; Laws 2014, chapter 189, sections 5; 10; 11; 16; 17; 18; 19; 23; 24; 27; 28; 29; 31; 43; 50; 51; 73; proposing coding for new law in Minnesota Statutes, chapters 62A; 62V; 144; 145; 148; 245; 245A; 256B; 256E; 256M; 256P; 518A; proposing coding for new law as Minnesota Statutes, chapters 245F; 256Q; repealing Minnesota Statutes 2014, sections 13.461, subdivision 26; 13D.08, subdivision 5a; 16A.724, subdivision 3; 62A.046, subdivision 5; 62V.01; 62V.02; 62V.03; 62V.04; 62V.05; 62V.06; 62V.07; 62V.08; 62V.09; 62V.10; 62V.11; 148.57, subdivisions 3, 4; 148.571; 148.572; 148.573, subdivision 1; 148.575, subdivisions 1, 3, 5, 6; 148.576; 148E.060, subdivision 12; 148E.075, subdivisions 4, 5, 6, 7; 214.105; 256.01, subdivision 35; 256B.434, subdivision 19b; 256B.441, subdivisions 14a, 19, 50a, 52, 55, 58, 62; 256D.0513; 256D.06, subdivision 8; 256D.09, subdivision 6; 256D.49; 256J.38; 256L.01, subdivisions 1, 1a, 1b, 2, 3, 3a, 5, 6, 7; 256L.02, subdivisions 1, 2, 3, 5, 6; 256L.03, subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 4a, 5, 6; 256L.04, subdivisions 1, 1a, 1c, 2, 2a, 7, 7a, 7b, 8, 10, 12, 13, 14; 256L.05, subdivisions 1, 1a, 1b, 1c, 2, 3, 3a, 3c, 4, 5, 6; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, 4; 256L.09, subdivisions 1, 2, 4, 5, 6, 7; 256L.10; 256L.11, subdivisions 1, 2, 2a, 3, 4, 7; 256L.12; 256L.121; 256L.15, subdivisions 1, 1a,

1b, 2; 256L.18; 256L.22; 256L.24; 256L.26; 256L.28; Minnesota Rules, part 3400.0170, subparts 5, 6, 12, 13.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2014, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency"

includes prepaid health plans under contract with the commissioner according to sections 256B.69, 256D.03, subdivision 4, paragraph (c), and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. If the health insurer needs additional information to process the claim, the health insurer may be granted an additional 30 business days to process the claim, provided the health insurer submits the request for additional information to the state agency within 30 business days after the health insurer received the claim.

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

Sec. 2. Minnesota Statutes 2014, section 150A.06, subdivision 1b, is amended to read:

Subd. 1b. **Resident dentists.** A person who is a graduate of a dental school and is an enrolled graduate student or student of an accredited advanced dental education program and who is not licensed to practice dentistry in the state shall obtain from the board a license to practice dentistry as a resident dentist. The license must be designated "resident dentist license" and authorizes the licensee to practice dentistry only under the supervision of a licensed dentist. A University of Minnesota School of Dentistry dental resident holding a resident dentist license is eligible for enrollment in medical assistance, as provided under section 256B.0625, subdivision 9b. A resident dentist license must be renewed annually pursuant to the board's rules. An applicant for a resident dentist license shall pay a nonrefundable fee set by the board for issuing and renewing the license. The requirements of sections 150A.01 to 150A.21 apply to resident dentists except as specified in rules adopted by the board. A resident dentist license does not qualify a person for licensure under subdivision 1.

Sec. 3. Minnesota Statutes 2014, section 151.58, subdivision 2, is amended to read:

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

(a) "Automated drug distribution system" or "system" means a mechanical system approved by the board that performs operations or activities, other than compounding or administration, related to the storage, packaging, or dispensing of drugs, and collects, controls, and maintains all required transaction information and records.

(b) "Health care facility" means a nursing home licensed under section 144A.02; a housing with services establishment registered under section 144D.01, subdivision 4, in which a home provider licensed under chapter 144A is providing centralized storage of medications; a boarding care home licensed under sections 144.50 to 144.58 that is providing centralized storage of medications; or a Minnesota sex offender program facility operated by the Department of Human Services.

(c) "Managing pharmacy" means a pharmacy licensed by the board that controls and is responsible for the operation of an automated drug distribution system.

Sec. 4. Minnesota Statutes 2014, section 151.58, subdivision 5, is amended to read:

Subd. 5. **Operation of automated drug distribution systems.** (a) The managing pharmacy and the pharmacist in charge are responsible for the operation of an automated drug distribution system.

(b) Access to an automated drug distribution system must be limited to pharmacy and nonpharmacy personnel authorized to procure drugs from the system, except that field

service technicians may access a system located in a health care facility for the purposes of servicing and maintaining it while being monitored either by the managing pharmacy, or a licensed nurse within the health care facility. In the case of an automated drug distribution system that is not physically located within a licensed pharmacy, access for the purpose of procuring drugs shall be limited to licensed nurses. Each person authorized to access the system must be assigned an individual specific access code. Alternatively, access to the system may be controlled through the use of biometric identification procedures. A policy specifying time access parameters, including time-outs, logoffs, and lockouts, must be in place.

(c) For the purposes of this section only, the requirements of section 151.215 are met if the following clauses are met:

(1) a pharmacist employed by and working at the managing pharmacy, or at a pharmacy that is acting as a central services pharmacy for the managing pharmacy, pursuant to Minnesota Rules, part 6800.4075, must review, interpret, and approve all prescription drug orders before any drug is distributed from the system to be administered to a patient. A pharmacy technician may perform data entry of prescription drug orders provided that a pharmacist certifies the accuracy of the data entry before the drug can be released from the automated drug distribution system. A pharmacist employed by and working at the managing pharmacy must certify the accuracy of the filling of any cassettes, canisters, or other containers that contain drugs that will be loaded into the automated drug distribution system, unless the filled cassettes, canisters, or containers have been provided by a repackager registered with the United States Food and Drug Administration and licensed by the board as a manufacturer; and

(2) when the automated drug dispensing system is located and used within the managing pharmacy, a pharmacist must personally supervise and take responsibility for all packaging and labeling associated with the use of an automated drug distribution system.

(d) Access to drugs when a pharmacist has not reviewed and approved the prescription drug order is permitted only when a formal and written decision to allow such access is issued by the pharmacy and the therapeutics committee or its equivalent. The committee must specify the patient care circumstances in which such access is allowed, the drugs that can be accessed, and the staff that are allowed to access the drugs.

(e) In the case of an automated drug distribution system that does not utilize bar coding in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician, so long as the activity is continuously supervised, through a two-way audiovisual system by a pharmacist on duty within the managing pharmacy. In the case of an automated drug distribution system that utilizes bar coding

in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician or a licensed nurse, provided that the managing pharmacy retains an electronic record of loading activities.

(f) The automated drug distribution system must be under the supervision of a pharmacist. The pharmacist is not required to be physically present at the site of the automated drug distribution system if the system is continuously monitored electronically by the managing pharmacy. A pharmacist on duty within a pharmacy licensed by the board must be continuously available to address any problems detected by the monitoring or to answer questions from the staff of the health care facility. The licensed pharmacy may be the managing pharmacy or a pharmacy which is acting as a central services pharmacy, pursuant to Minnesota Rules, part 6800.4075, for the managing pharmacy.

Sec. 5. Minnesota Statutes 2014, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For rate setting periods after November 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year for the rates effective November 1, 2014, shall

be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were made for the same number and types of services in the base year. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through June 30, 2016, the rebased rates under paragraph (c) shall include adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, through June 30, 2016, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low-volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year payment rate per admission is standardized by the applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, interim per diem payment rates shall be based on the ratio of cost and charges reported on the base year Medicare cost report or reports and applied to medical assistance utilization data. Final settlement payments for a state fiscal year must be determined based on a review of the medical assistance cost report required under subdivision 4b for the applicable state fiscal year;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates under this section shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. The commissioner shall establish the base year for each rebasing period considering the most recent year for which filed Medicare cost reports are available. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, 2015, payment rates for critical access hospitals located in Minnesota or the local trade area shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Annual payments to hospitals under this paragraph shall equal the total cost for critical access hospitals as reflected in base year cost reports. The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. The factors used to develop the new methodology may include but are not limited to:

(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;

(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;

(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and

(6) geographic location.

Sec. 6. Minnesota Statutes 2014, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

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

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1.

The commissioner may establish a separate disproportionate population payment rate adjustment for critical access hospitals. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

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

(d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid in accordance with a new methodology. Annual DSH payments made under this paragraph shall equal the total amount of DSH payments made for 2012. The new methodology shall take into account a variety of factors, including but not limited to:

(1) the medical assistance utilization rate of the hospitals that receive payments under this subdivision;

(2) whether the hospital is located within Minnesota;

(3) the difference between a hospital's costs for treating medical assistance patients and the total amount of payments received from medical assistance;

(4) the percentage of uninsured patient days at each qualifying hospital in relation to the total number of uninsured patient days statewide;

(5) the hospital's status as a hospital authorized to make presumptive eligibility determinations for medical assistance in accordance with section 256B.057, subdivision 12;

(6) the hospital's status as a safety net, critical access, children's, rehabilitation, or long-term hospital;

(7) whether the hospital's administrative cost of compiling the necessary DSH reports exceeds the anticipated value of any calculated DSH payment; and

(8) whether the hospital provides specific services designated by the commissioner to be of particular importance to the medical assistance program.

(e) Any payments or portion of payments made to a hospital under this subdivision that are subsequently returned to the commissioner because the payments are found to exceed the hospital-specific DSH limit for that hospital shall be redistributed to other DSH-eligible hospitals in a manner established by the commissioner.

Sec. 7. Minnesota Statutes 2014, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard specified in subdivision 4, paragraph (b).

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years shall equal ~~75~~ 80 percent of the federal poverty guidelines.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 8. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 9b. **Dental services provided by faculty members and resident dentists at a dental school.** (a) A dentist who is not enrolled as a medical assistance provider, is a faculty or adjunct member at the University of Minnesota or a resident dentist licensed under section 150A.06, subdivision 1b, and is providing dental services at a dental clinic owned or operated by the University of Minnesota, may be enrolled as a medical assistance provider if the provider completes and submits to the commissioner an agreement form developed by the commissioner. The agreement must specify that the faculty or adjunct member or resident dentist:

(1) will not receive payment for the services provided to medical assistance or MinnesotaCare enrollees performed at the dental clinics owned or operated by the University of Minnesota;

(2) will not be listed in the medical assistance or MinnesotaCare provider directory; and

(3) is not required to serve medical assistance and MinnesotaCare enrollees when providing nonvolunteer services in a private practice.

(b) A dentist or resident dentist enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from medical assistance or MinnesotaCare as a fee-for-service provider.

Sec. 9. Minnesota Statutes 2014, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and

excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the ~~lower~~ lowest of:

(1) the number of dosage units contained in the manufacturer's original package; ~~and~~

(2) the number of dosage units required to complete the patient's course of therapy; or

(3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

EFFECTIVE DATE. This section is effective January 1, 2016, or upon federal approval, whichever is later.

Sec. 10. Minnesota Statutes 2014, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65 for legend prescription drugs, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. The pharmacy dispensing fee for over-the-counter drugs shall be $3.65, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list

price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescriptions dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period of not less than one calendar month or 30 days.

(c) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. ~~The~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, subpart 2, will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

~~(c)~~ (d) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

~~(d)~~ (e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

~~(e)~~ (f) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

~~(f)~~ (g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective January 1, 2016, or upon federal approval, whichever is later.

Sec. 11. Minnesota Statutes 2014, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance ~~and general assistance medical care cover~~ covers medication therapy management services for a recipient taking ~~three or more~~ prescriptions to treat or prevent one or more chronic medical conditions~~; a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective~~. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and

documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance ~~and general assistance medical care~~ providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of paragraph (b), clause (3). The patient must also be located within an ambulatory care setting ~~approved by the commissioner~~ that meets the requirements of paragraph (b), clause (3). Services provided under this paragraph may not be transmitted into the patient's residence.

~~(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.~~

(e) Medication therapy management services may be delivered into a patient's residence via secure interactive video if the medication therapy management services are performed electronically during a covered home care visit by an enrolled provider. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b) and must be located within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).

Sec. 12. Minnesota Statutes 2014, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services. Nonemergency medical transportation service includes, but is not limited to, special transportation service, defined in section 174.29, subdivision 1.

(b) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs and public transit, as defined in section 174.22, subdivision 7; or

(4) not-for-hire vehicles, including volunteer drivers.

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of Transportation. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(d) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services.

(e) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes under paragraph (h), clauses (4), (5), (6), and (7).

(f) The commissioner may use an order by the recipient's attending physician or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Nonemergency medical transportation providers must have trip logs, which include pickup and drop-off times, signed by the medical provider or client attesting mileage traveled to obtain covered medical services, whichever is deemed most appropriate. Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must take clients to the health care provider, using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency. The minimum medical assistance reimbursement rates for special transportation services are:

(1)(i) $17 for the base rate and $1.35 per mile for special transportation services to eligible persons who need a wheelchair-accessible van;

(ii) $11.50 for the base rate and $1.30 per mile for special transportation services to eligible persons who do not need a wheelchair-accessible van; and

(iii) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for special transportation services to eligible persons who need a stretcher-accessible vehicle; and

(2) clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(g) The covered modes of nonemergency medical transportation include transportation provided directly by clients or family members of clients with their own transportation, volunteers using their own vehicles, taxicabs, and public transit, or provided to a client who needs a stretcher-accessible vehicle, a lift/ramp equipped vehicle, or a vehicle that is not stretcher-accessible or lift/ramp equipped designed to transport ten or fewer persons. Upon implementation of a new rate structure, a new covered mode of nonemergency medical transportation shall include transportation provided to a client who needs a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver.

(h) The administrative agency shall use the level of service process established by the commissioner in consultation with the Nonemergency Medical Transportation Advisory Committee to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade. The new modes of transportation, which may not be implemented without a new rate structure, are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation or family who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or publicly operated transit system is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(i) ~~In accordance with subdivision 18e, by July 1, 2016,~~ The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (h) according to a new rate structure, ~~once this is adopted~~ when the commissioner has developed, made available, and funded the Web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or the federal government.

(j) The commissioner shall:

(1) in consultation with the Nonemergency Medical Transportation Advisory Committee, verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(k) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

(l) The base rates for special transportation services in areas defined under RUCA to be super rural shall be equal to the reimbursement rate established in paragraph (f), clause (1), plus 11.3 percent, and for special transportation services in areas defined under RUCA to be rural or super rural areas:

(1) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125 percent of the respective mileage rate in paragraph (f), clause (1); and

(2) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to 112.5 percent of the respective mileage rate in paragraph (f), clause (1).

(m) For purposes of reimbursement rates for special transportation services under paragraph (c), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(n) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(o) Effective for services provided on or after September 1, 2011, nonemergency transportation rates, including special transportation, taxi, and other commercial carriers, are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Sec. 13. Minnesota Statutes 2014, section 256B.0625, subdivision 28a, is amended to read:

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments or providing clinical supervision.

Sec. 14. Minnesota Statutes 2014, section 256B.0625, subdivision 31, is amended to read:

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

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

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

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

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

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

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

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

(1) can withstand repeated use;

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

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

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

Sec. 15. Minnesota Statutes 2014, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for ~~vaccines~~ health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 16. Minnesota Statutes 2014, section 256B.0631, is amended to read:

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) ~~effective January 1, 2012,~~ a family deductible equal to ~~the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54~~ $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) ~~for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines,~~ total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible;

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room; ~~and~~

(10) services, fee-for-service payments subject to volume purchase through competitive bidding~~.~~;

(11) American Indians who meet the requirements in Code of Federal Regulations, title 42, section 447.51;

(12) persons needing treatment for breast or cervical cancer as described under section 256B.057, subdivision 10; and

(13) services that currently have a rating of A or B from the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130.

Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment or deductible, except that reimbursements shall not be reduced:

(1) once a recipient has reached the $12 per month maximum for prescription drug co-payments; or

(2) for a recipient ~~identified by the commissioner under 100 percent of the federal poverty guidelines~~ who has met their monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment or deductible.

(c) Medical assistance reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of co-payments or deductibles effective on or after January 1, 2009.

EFFECTIVE DATE. The amendment to subdivision 1, paragraph (a), clause (4), is effective retroactively from January 1, 2014.

Sec. 17. Minnesota Statutes 2014, section 256B.0644, is amended to read:

256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

(a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the Department of Human Services. This section does not apply to dental service providers providing dental services outside the seven-county metropolitan area.

(b) For providers other than health maintenance organizations, participation in the medical assistance program means that:

(1) the provider accepts new medical assistance and MinnesotaCare patients;

(2) for providers other than dental service providers, at least 20 percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage; or

(3) for dental service providers providing dental services in the seven-county metropolitan area, at least ten percent of the provider's patients are covered by medical assistance and MinnesotaCare as their primary source of coverage, or the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this section, "children with special health care needs" means children up to age 18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

EFFECTIVE DATE. This section is effective upon receipt of any necessary federal waiver or approval. The commissioner of human services shall notify the revisor of statutes if a federal waiver or approval is sought and, if sought, when a federal waiver or approval is obtained.

Sec. 18. **[256B.0758] HEALTH CARE DELIVERY PILOT PROGRAM.**

(a) The commissioner may establish a health care delivery pilot program to test alternative and innovative integrated health care delivery networks, including accountable care organizations or a community-based collaborative care network created by or

including North Memorial Health Care. If required, the commissioner shall seek federal approval of a new waiver request or amend an existing demonstration pilot project waiver.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055. The commissioner may identify individuals to be enrolled in the pilot program based on zip code or whether the individuals would benefit from an integrated health care delivery network.

(c) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the individuals enrolled in the pilot program that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

Sec. 19. Minnesota Statutes 2014, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets

must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate

with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23

and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public programs. Subcontractor agreements of over $200,000 in annual payments must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, and consideration, and must clearly indicate how the agreements relate to state public programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

Sec. 20. Minnesota Statutes 2014, section 256B.69, subdivision 5i, is amended to read:

Subd. 5i. **Administrative expenses.** (a) ~~Managed care plan and county-based purchasing plan~~ Administrative costs ~~for a prepaid health plan provided~~ paid to managed care plans and county-based purchasing plans under this section ~~or~~, section 256B.692, and section 256L.12 must not exceed ~~by more than five~~ 6.6 percent ~~that prepaid health plan's or county-based purchasing plan's actual calculated administrative spending for the previous calendar year as a percentage of total revenue~~ of total payments expected to be made to all managed care plans and county-based purchasing plans in aggregate across all state public programs at the beginning of each calendar year. ~~The penalty for exceeding this limit must be the amount of administrative spending in excess of 105 percent of the actual calculated amount. The commissioner may waive this penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.~~ The commissioner may reduce or eliminate administrative requirements to meet the administrative cost limit. For purposes of this paragraph, administrative costs do not include any state or federal taxes, surcharges, or assessments.

(b) The following expenses are not allowable administrative expenses for rate-setting purposes under this section:

(1) charitable contributions made by the managed care plan or the county-based purchasing plan;

(2) ~~any portion of an individual's compensation in excess of $200,000 paid by the managed care plan or county-based purchasing plan~~ compensation of individuals within the organization, other than the medical director, in excess of $200,000 such that the allocation of compensation for an individual across all state public programs in total cannot exceed $200,000;

(3) any penalties or fines assessed against the managed care plan or county-based purchasing plan; ~~and~~

(4) any indirect marketing or advertising expenses of the managed care plan or county-based purchasing plan. for marketing that does not specifically target state public programs beneficiaries and that has not been approved by the commissioner;

(5) any lobbying and political activities, events, or contributions;

(6) administrative expenses related to the provision of services not covered under the state plan or waiver;

(7) alcoholic beverages and related costs;

(8) membership in any social, dining, or country club or organization; and

(9) entertainment, including amusement, diversion, and social activities, and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities.

For the purposes of this subdivision, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits. Contributions include payments for or to any organization or entity selected by the health maintenance organization that is operated for charitable, educational, political, religious, or scientific purposes and not related to the provision of medical and administrative services covered under the state public programs, except to the extent that they improve access to or the quality of covered services for state public programs beneficiaries, or improve the health status of state public programs beneficiaries.

(c) Administrative expenses must be reported using the formats designated by the commissioner as part of the rate-setting process and must include, at a minimum, the following categories:

(1) employee benefit expenses;

(2) sales expenses;

(3) general business and office expenses;

(4) taxes and assessments;

(5) consulting and professional fees; and

(6) outsourced services.

Definitions of items to be included in each category shall be provided by the commissioner with quarterly financial filing requirements and shall be aligned with definitions used by the Departments of Commerce and Health in financial reporting for commercial carriers. Where reasonably possible, expenses for an administrative item shall be directly allocated so as to assign costs for an item to an individual state public program when the cost can be specifically identified with and benefits the individual state public program. For administrative services expensed to the state's public programs, managed care plans

and county-based purchasing plans must clearly identify and separately record expense items listed under paragraph (b) in their accounting systems in a manner that allows for independent verification of unallowable expenses for purposes of determining payment rates for state public programs.

(d) The administrative expenses requirement of this subdivision also apply to demonstration providers under section 256B.0755.

Sec. 21. Minnesota Statutes 2014, section 256B.69, subdivision 9c, is amended to read:

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Effective January 1, 2014, each managed care and county-based purchasing plan must quarterly provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) an income statement by program;

(2) financial statement footnotes;

(3) quarterly profitability by program and population group;

(4) a medical liability summary by program and population group;

(5) received but unpaid claims report by program;

(6) services versus payment lags by program for hospital services, outpatient services, physician services, other medical services, and pharmaceutical benefits;

(7) utilization reports that summarize utilization and unit cost information by program for hospitalization services, outpatient services, physician services, and other medical services;

(8) pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services;

(9) subcapitation expenses by population group;

(10) third-party payments by program;

(11) all new, active, and closed subrogation cases by program;

(12) all new, active, and closed fraud and abuse cases by program;

(13) medical loss ratios by program;

(14) administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies;

(15) revenues by program, including investment income;

(16) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(17) data on the amount of reinsurance or transfer of risk by program; and

(18) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 15 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 15 days to review the report and provide comment to the commissioner.

The quarterly reports shall be submitted to the commissioner no later than 60 days after the end of the previous quarter, except the fourth-quarter report, which shall be submitted by April 1 of each year. The fourth-quarter report shall include audited financial statements, parent company audited financial statements, an income statement reconciliation report,

and any other documentation necessary to reconcile the detailed reports to the audited financial statements.

(d) Managed care plans and county-based purchasing plans shall certify to the commissioner, for the purpose of managed care financial reporting for state public health care programs under this subdivision, that costs related to state public health care programs include only services covered under the state plan and waivers, and related allowable administrative expenses. Managed care plans and county-based purchasing plans shall certify and report to the commissioner the dollar value of any unallowable and nonstate plan services, including both medical and administrative expenditures, for the purposes of managed care financial reporting under this subdivision.

(e) The financial reporting requirements of this subdivision also apply to demonstration providers under section 256B.0755.

Sec. 22. Minnesota Statutes 2014, section 256B.69, subdivision 9d, is amended to read:

Subd. 9d. **Financial ~~audit~~ and quality assurance audits.** ~~(a) The legislative auditor shall contract with an audit firm to conduct a biennial independent third-party financial audit of the information required to be provided by managed care plans and county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be conducted in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the audit firm shall be designed and administered so as to render the independent third-party audit eligible for a federal subsidy, if available. The contract shall require the audit to include a determination of compliance with the federal Medicaid rate certification process. The contract shall require the audit to determine if the administrative expenses and investment income reported by the managed care plans and county-based purchasing plans are compliant with state and federal law.~~

~~(b) For purposes of this subdivision, "independent third party" means an audit firm that is independent in accordance with government auditing standards issued by the United States Government Accountability Office and licensed in accordance with chapter 326A. An audit firm under contract to provide services in accordance with this subdivision must not have provided services to a managed care plan or county-based purchasing plan during the period for which the audit is being conducted.~~

~~(c)~~ (a) The commissioner shall require, in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section and section 256B.692, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial ~~audit~~ audits by the

legislative auditor under subdivision 9e of the information required under subdivision 9c, paragraph (b). Each contract with a managed care plan or county-based purchasing plan under this section or section 256B.692 must provide the commissioner and the ~~audit firm~~ vendors contracting with the legislative auditor access to all data required to complete ~~the audit. For purposes of this subdivision, the contracting audit firm shall have the same investigative power as the legislative auditor under section 3.978, subdivision 2~~ audits under subdivision 9e.

~~(d)~~ (b) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols. ~~The audit firm under contract to provide this evaluation must meet the requirements in paragraph (b).~~

~~(e) Upon completion of the audit under paragraph (a) and receipt by the legislative auditor, the legislative auditor shall provide copies of the audit report to the commissioner, the state auditor, the attorney general, and the chairs and ranking minority members of the health and human services finance committees of the legislature.~~ (c) Upon completion of the evaluation under paragraph ~~(d)~~ (b), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the ~~health finance committees of the legislature~~ legislative committees with jurisdiction over health care policy and financing.

~~(f)~~ (d) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this section and section 256B.692 during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section and section 256B.692, and the certification and attestation must be auditable.

(e) The commissioner may conduct ad hoc audits of the state public programs administrative and medical expenses of managed care organizations and county-based

purchasing plans. This includes: financial and encounter data reported to the commissioner under subdivision 9c, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public programs. These audits also must monitor compliance with data and financial certifications provided to the commissioner for the purposes of managed care capitation payment rate-setting. The managed care plans and county-based purchasing plans shall fully cooperate with the audits in this subdivision.

~~(g)~~ (f) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

(g) The audit requirements of this subdivision also apply to demonstration providers under section 256B.0755.

Sec. 23. Minnesota Statutes 2014, section 256B.69, is amended by adding a subdivision to read:

Subd. 9e. **Financial audits.** (a) The legislative auditor shall contract with vendors to conduct independent third-party financial audits of the Department of Human Services' use of the information required to be provided by managed care plans and county-based purchasing plans under subdivision 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources permit and in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office. The contract with the vendors shall be designed and administered so as to render the independent third-party audits eligible for a federal subsidy, if available. The contract shall require the audits to include a determination of compliance by the Department of Human Services with the federal Medicaid rate certification process.

(b) For purposes of this subdivision, "independent third-party" means a vendor that is independent in accordance with government auditing standards issued by the United States Government Accountability Office.

Sec. 24. Minnesota Statutes 2014, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital

facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(g) Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under paragraph (b) for the applicable payment year shall be the final payment and shall not be settled to actual costs.

Sec. 25. Minnesota Statutes 2014, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments

made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

Sec. 26. Minnesota Statutes 2014, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing

plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, payment rates for dental services shall be increased by five percent from the rates in effect on June 30, 2015. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, payments to managed care plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

Sec. 27. Minnesota Statutes 2014, section 256B.762, is amended to read:

256B.762 REIMBURSEMENT FOR HEALTH CARE SERVICES.

(a) Effective for services provided on or after October 1, 2005, payment rates for the following services shall be increased by five percent over the rates in effect on September 30, 2005, when these services are provided as home health services under section 256B.0625, subdivision 6a:

(1) skilled nursing visit;

(2) physical therapy visit;

(3) occupational therapy visit;

(4) speech therapy visit; and

(5) home health aide visit.

(b) Effective for services provided on or after July 1, 2015, payment rates for managed care and fee-for-service visits for the following services shall be increased by ten percent over the rates in effect on June 30, 2015, when these services are provided as home health services under section 256B.0625, subdivision 6a:

(1) physical therapy;

(2) occupational therapy; and

(3) speech therapy.

The commissioner shall adjust managed care and county-based purchasing plan capitation rates to reflect the payment rates under this paragraph.

Sec. 28. Minnesota Statutes 2014, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical

assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates ~~in effect on June 30, 2014~~ as determined under paragraph (i).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a

volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(i) Effective July 1, 2015, the medical assistance payment rate for durable medical equipment, prosthetics, orthotics, or supplies shall be restored to the January 1, 2008, medical assistance fee schedule, updated to include subsequent rate increases in the Medicare and medical assistance fee schedules, and including individually priced items for the following categories: enteral nutrition and supplies, customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item.

Sec. 29. Minnesota Statutes 2014, section 256B.767, is amended to read:

256B.767 MEDICARE PAYMENT LIMIT.

(a) Effective for services rendered on or after July 1, 2010, fee-for-service payment rates for physician and professional services under section 256B.76, subdivision 1, and basic care services subject to the rate reduction specified in section 256B.766, shall not exceed the Medicare payment rate for the applicable service, as adjusted for any changes in Medicare payment rates after July 1, 2010. The commissioner shall implement this section after any other rate adjustment that is effective July 1, 2010, and shall reduce rates under this section by first reducing or eliminating provider rate add-ons.

(b) This section does not apply to services provided by advanced practice certified nurse midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D. Notwithstanding this exemption, medical assistance fee-for-service payment rates for advanced practice certified nurse midwives and licensed traditional midwives shall equal and shall not exceed the medical assistance payment rate to physicians for the applicable service.

(c) This section does not apply to mental health services or physician services billed by a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

~~(d) Effective for durable medical equipment, prosthetics, orthotics, or supplies provided on or after July 1, 2013, through June 30, 2015, the payment rate for items that are subject to the rates established under Medicare's National Competitive Bidding Program shall be equal to the rate that applies to the same item when not subject to the rate established under Medicare's National Competitive Bidding Program. This paragraph does not apply to mail-order diabetic supplies and does not apply to items provided to dually eligible recipients when Medicare is the primary payer of the item.~~

(d) Effective July 1, 2015, this section shall not apply to durable medical equipment, prosthetics, orthotics, or supplies.

(e) This section does not apply to physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).

Sec. 30. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:

Subd. 5. **Basic Health Care Grants**

(a) **MinnesotaCare Grants**

Health Care Access	-0-	(770,000)

Incentive Program and Outreach Grants.
Of the appropriation for the Minnesota health care outreach program in Laws 2007, chapter 147, article 19, section 3, subdivision 7, paragraph (b):

(1) $400,000 in fiscal year 2009 from the general fund and $200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the biennium beginning July 1, 2009, base level funding for this activity shall be $360,000 from the general fund and $160,000 from the health care access fund; and

(2) $100,000 in fiscal year 2009 from the general fund and $50,000 in fiscal year 2009 from the health care access fund are for the outreach grants under Minnesota Statutes, section 256.962, subdivision 2. For the biennium beginning July 1, 2009, base level funding for this activity shall be $90,000 from the general fund and $40,000 from the health care access fund.

(b) **MA Basic Health Care Grants - Families and Children** -0- (17,280,000)

Third-Party Liability. (a) During fiscal year 2009, the commissioner shall employ a contractor paid on a percentage basis to improve third-party collections. Improvement initiatives may include, but not be limited to, efforts to improve postpayment collection from nonresponsive claims and efforts to uncover third-party payers the commissioner has been unable to identify.

(b) In fiscal year 2009, the first $1,098,000 of recoveries, after contract payments and federal repayments, is appropriated to the commissioner for technology-related expenses.

~~**Administrative Costs.** (a) For contracts effective on or after January 1, 2009, the commissioner shall limit aggregate administrative costs paid to managed care plans under Minnesota Statutes, section 256B.69, and to county-based purchasing plans under Minnesota Statutes, section 256B.692, to an overall average of 6.6 percent of total contract payments under Minnesota Statutes, sections 256B.69 and 256B.692, for each calendar year. For purposes of~~

~~this paragraph, administrative costs do not include premium taxes paid under Minnesota Statutes, section 297I.05, subdivision 5, and provider surcharges paid under Minnesota Statutes, section 256.9657, subdivision 3.~~

~~(b) Notwithstanding any law to the contrary, the commissioner may reduce or eliminate administrative requirements to meet the administrative target under paragraph (a).~~

~~(c) Notwithstanding any contrary provision of this article, this rider shall not expire.~~

Hospital Payment Delay. Notwithstanding Laws 2005, First Special Session chapter 4, article 9, section 2, subdivision 6, payments from the Medicaid Management Information System that would otherwise have been made for inpatient hospital services for medical assistance enrollees are delayed as follows: (1) for fiscal year 2008, June payments must be included in the first payments in fiscal year 2009; and (2) for fiscal year 2009, June payments must be included in the first payment of fiscal year 2010. The provisions of Minnesota Statutes, section 16A.124, do not apply to these delayed payments. Notwithstanding any contrary provision in this article, this paragraph expires on June 30, 2010.

(c) **MA Basic Health Care Grants - Elderly and Disabled**	(14,028,000)	(9,368,000)

Minnesota Disability Health Options Rate Setting Methodology. The commissioner shall develop and implement a methodology for risk adjusting payments for community alternatives for disabled individuals (CADI)

and traumatic brain injury (TBI) home and community-based waiver services delivered under the Minnesota disability health options program (MnDHO) effective January 1, 2009. The commissioner shall take into account the weighting system used to determine county waiver allocations in developing the new payment methodology. Growth in the number of enrollees receiving CADI or TBI waiver payments through MnDHO is limited to an increase of 200 enrollees in each calendar year from January 2009 through December 2011. If those limits are reached, additional members may be enrolled in MnDHO for basic care services only as defined under Minnesota Statutes, section 256B.69, subdivision 28, and the commissioner may establish a waiting list for future access of MnDHO members to those waiver services.

MA Basic Elderly and Disabled Adjustments. For the fiscal year ending June 30, 2009, the commissioner may adjust the rates for each service affected by rate changes under this section in such a manner across the fiscal year to achieve the necessary cost savings and minimize disruption to service providers, notwithstanding the requirements of Laws 2007, chapter 147, article 7, section 71.

(d) **General Assistance Medical Care Grants**	-0-	(6,971,000)
(e) **Other Health Care Grants**	-0-	(17,000)

MinnesotaCare Outreach Grants Special Revenue Account. The balance in the MinnesotaCare outreach grants special

revenue account on July 1, 2009, estimated to be $900,000, must be transferred to the general fund.

Grants Reduction. Effective July 1, 2008, base level funding for nonforecast, general fund health care grants issued under this paragraph shall be reduced by 1.8 percent at the allotment level.

Sec. 31. **REDUCTION IN ADMINISTRATIVE COSTS.**

The commissioner of human services, when contracting with managed care and county-based purchasing plans for the provision of services under Minnesota Statutes, sections 256B.69 and 256B.692, for calendar years 2016 and 2017, shall negotiate reductions in managed care and county-based purchasing plan administrative costs, sufficient to achieve a state medical assistance savings of $100,000,000 for the biennium ending June 30, 2017.

Sec. 32. **ADVISORY GROUP ON ADMINISTRATIVE EXPENSES.**

Subdivision 1. **Duties.** The commissioner of health shall reconvene the Advisory Group on Administrative Expenses, established under Laws 2010, First Special Session chapter 1, article 20, section 3, to develop detailed standards and procedures for examining the reasonableness of administrative expenses by individual state public programs. The advisory group shall develop consistent guidelines, definitions, and reporting requirements, including a common standardized public reporting template for health maintenance organizations and county-based purchasing plans that participate in state public programs. The advisory group shall take into consideration relevant reporting standards of the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services. The advisory group shall expire on January 1, 2016.

Subd. 2. **Membership.** The advisory group shall be composed of the following members, who serve at the pleasure of their appointing authority:

(1) the commissioner of health or the commissioner's designee;

(2) the commissioner of human services or the commissioner's designee;

(3) the commissioner of commerce or the commissioner's designee; and

(4) representatives of health maintenance organizations and county-based purchasing plans appointed by the commissioner of health.

Sec. 33. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay $135,000,000 of the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2017 and the payment due in April 2017 for special needs basic care until July 1, 2017. The payment shall be made no earlier than July 1, 2017, and no later than July 31, 2017.

(b) The commissioner of human services shall delay $135,000,000 of the medical assistance capitation payment to managed care plans and county-based purchasing plans due in the second quarter of calendar year 2019 and the April 2019 payment for special needs basic care until July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July 31, 2019.

Sec. 34. **HEALTH AND ECONOMIC ASSISTANCE PROGRAM ELIGIBILITY VERIFICATION AUDIT SERVICES.**

Subdivision 1. **Request for proposals.** By October 1, 2015, the commissioner of human services shall issue a request for proposals for a contract to provide eligibility verification audit services for benefits provided through health and economic assistance programs. The request for proposals must require that the vendor:

(1) conduct an eligibility verification audit of all health and economic assistance program recipients that includes, but is not limited to, appropriate data matching against relevant state and federal databases;

(2) identify any ineligible recipients in these programs and report those findings to the commissioner; and

(3) identify a process for ongoing eligibility verification of health and economic assistance program recipients and applicants, following the conclusion of the eligibility verification audit required by this section.

Subd. 2. **Additional vendor criteria.** The request for proposals must require the vendor to provide the following minimum capabilities and experience in performing the services described in subdivision 1:

(1) a rules-based process for making objective eligibility determinations;

(2) assigned eligibility advocates to assist recipients through the verification process;

(3) a formal claims and appeals process; and

(4) experience in the performance of eligibility verification audits.

Subd. 3. **Contract required.** (a) By January 1, 2016, the commissioner must enter into a contract for the services specified in subdivision 1. The contract must:

(1) incorporate performance-based vendor financing that compensates the vendor based on the amount of savings generated by the work performed under the contract;

(2) require the vendor to reimburse the commissioner and county agencies for all reasonable costs incurred in implementing this section, out of savings generated by the work performed under the contract;

(3) require the vendor to comply with enrollee data privacy requirements and to use encryption to safeguard enrollee identity; and

(4) provide penalties for vendor noncompliance.

(b) The commissioner may renew the contract for up to three additional one-year periods. The commissioner may require additional eligibility verification audits, if the commissioner or the legislative auditor determines that the MNsure information technology system and agency eligibility determination systems cannot effectively verify the eligibility of health and economic assistance program recipients.

Subd. 4. **Health and economic assistance program.** For purposes of this section, "health and economic assistance program" means the medical assistance program under Minnesota Statutes, chapter 256B, Minnesota family investment and diversionary work programs under Minnesota Statutes, chapter 256J, child care assistance programs under Minnesota Statutes, chapter 119B, general assistance under Minnesota Statutes, sections 256D.01 to 256D.23, alternative care program under Minnesota Statutes, section 256B.0913, and chemical dependency programs funded under Minnesota Statutes, chapter 254B.

Sec. 35. **REQUEST FOR PROPOSALS.**

(a) The commissioner of human services shall issue a request for proposals for a contract to use technologically advanced software and services to improve the identification and rejection or elimination of:

(1) improper Medicaid payments before payment is made to the provider; and

(2) improper provision of benefits by a health and economic assistance program to ineligible individuals.

(b) The request for proposals must ensure that a system recommended and implemented by the contractor will:

(1) implement a more comprehensive, robust, and technologically advanced improper payments and benefits identification program;

(2) utilize state of the art fraud detection methods and technologies such as predictive modeling, link analysis, and anomaly and outlier detection;

(3) have the ability to identify and report improper claims before the claims are paid;

(4) have the ability to identify and report the improper provision of benefits under a health and economic assistance program;

(5) include a mechanism so that the system improves its detection capabilities over time;

(6) leverage technology to make the Medicaid claims evaluation process more transparent and cost-efficient; and

(7) result in increased state savings by reducing or eliminating payouts of wrongful Medicaid claims and the improper provision of health and economic assistance program benefits.

(c) Based on responses to the request for proposals, the commissioner must enter into a contract for the services specified in paragraphs (a) and (b) by October 1, 2015. The contract shall incorporate a performance-based vendor financing option whereby the vendor shares in the risk of the project's success.

(d) For purposes of this section, "health and economic assistance program" means the medical assistance program under Minnesota Statutes, chapter 256B, Minnesota family investment and diversionary work programs under Minnesota Statutes, chapter 256J, child care assistance programs under Minnesota Statutes, chapter 119B, general assistance under Minnesota Statutes, sections 256D.01 to 256D.23, alternative care program under Minnesota Statutes, section 256B.0913, and chemical dependency programs funded under Minnesota Statutes, chapter 254B.

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

Sec. 36. **FEDERAL WAIVER OR APPROVAL.**

The commissioner of human services shall seek any federal waiver or approval necessary to implement the amendments to Minnesota Statutes, section 256B.0644.

ARTICLE 2

MINNESOTACARE

Section 1. Minnesota Statutes 2014, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapters 256B, 256D, 256J, 256K, or 256L, and child care assistance programs, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or vouchers produced according to sections 145.891 to 145.897 and ~~MinnesotaCare services according to sections~~ premium assistance under section 256.9365~~, 256.94, and 256L.01 to 256L.15~~, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 2. Minnesota Statutes 2014, section 256B.021, subdivision 4, is amended to read:

Subd. 4. **Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with sections 256B.0755 and 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives through Medicaid and MinnesotaCare enrollee cost-sharing and other means to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit~~, and to impose a 180-day durational residency requirement in MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children, regardless of income~~.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

(1) coordination with health care homes or health care coordinators;

(2) assessment for wellness, housing needs, employment, planning, and goal setting;

(3) training services;

(4) job placement services;

(5) career counseling;

(6) benefit counseling;

(7) worker supports and coaching;

(8) assessment of workplace accommodations;

(9) transitional housing services; and

(10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

(1) provide people less expensive alternatives to medical assistance services;

(2) offer more flexible and updated community support services under the Medicaid state plan;

(3) provide an individual budget and increased opportunity for self-direction;

(4) strengthen family and caregiver support services;

(5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;

(6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;

(7) target access to residential care for those with higher needs;

(8) develop capacity within the community for crisis intervention and prevention;

(9) redesign case management;

(10) offer life planning services for families to plan for the future of their child with a disability;

(11) enhance self-advocacy and life planning for people with disabilities;

(12) improve information and assistance to inform long-term care decisions; and

(13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 3. Minnesota Statutes 2014, section 256L.01, subdivision 3a, is amended to read:

Subd. 3a. **Family.** (a) Except as provided in paragraphs (c) and (d), "family" has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

(c) For an individual who does not expect to file a federal tax return and does not expect to be claimed as a dependent for the applicable tax year, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(3).

(d) For a married couple, "family" has the meaning given in Code of Federal Regulations, title 42, section 435.603(f)(4).

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

Sec. 4. Minnesota Statutes 2014, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1., and means a household's projected annual income for the applicable tax year.

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

Sec. 5. Minnesota Statutes 2014, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in this subdivision, the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

(1) $3 per prescription for adult enrollees;

(2) $25 for eyeglasses for adult enrollees;

(3) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or

physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(4) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

(5) a family deductible equal to ~~the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.~~ $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next-higher five-cent increment.

(b) Paragraph (a) does not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 447.51.

(c) Paragraph (a), clause (3), does not apply to mental health services.

(d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (4), effective January 1, 2011.

(e) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (5). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

EFFECTIVE DATE. The amendment to paragraph (a), clause (5), is effective retroactively from January 1, 2014. The amendment to paragraph (b) is effective the day following final enactment.

Sec. 6. Minnesota Statutes 2014, section 256L.04, subdivision 1c, is amended to read:

Subd. 1c. **General requirements.** To be eligible for ~~coverage under~~ MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

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

Sec. 7. Minnesota Statutes 2014, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section ~~each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009~~ annually on January 1 as provided in Code of Federal Regulations, title 26, section 1.36B-1(h).

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

Sec. 8. Minnesota Statutes 2014, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title ~~8~~ 45, section ~~103.12~~ 152.2. Undocumented noncitizens are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

Sec. 9. Minnesota Statutes 2014, section 256L.05, is amended by adding a subdivision to read:

Subd. 2a. **Eligibility and coverage.** For purposes of this chapter, an individual is eligible for MinnesotaCare following a determination by the commissioner that the individual meets the eligibility criteria for the applicable period of eligibility. For an individual required to pay a premium, coverage is only available in each month of the applicable period of eligibility for which a premium is paid.

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

Sec. 10. Minnesota Statutes 2014, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium

payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of the month following the month in which ~~verification of American Indian status is received or~~ eligibility is approved~~, whichever is later~~.

Sec. 11. Minnesota Statutes 2014, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **~~Renewal~~ Redetermination of eligibility.** (a) ~~Beginning July 1, 2007,~~ An enrollee's eligibility must be ~~renewed every 12 months~~ redetermined on an annual basis. ~~The 12-month period begins in the month after the month the application is approved.~~ The period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Beginning in calendar year 2015, eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. ~~An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received~~ Coverage begins as provided in section 256L.06 ~~in order for eligibility to continue~~.

~~(c) For children enrolled in MinnesotaCare, the first period of renewal begins the month the enrollee turns 21 years of age.~~

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

Sec. 12. Minnesota Statutes 2014, section 256L.05, subdivision 4, is amended to read:

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than ~~30~~ 45 days from the date that the application is received by the Department of Human Services as set forth in Code of Federal Regulations, title 42, section 435.911. ~~Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare.~~

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

Sec. 13. Minnesota Statutes 2014, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month following the month for which the premium was due. Persons disenrolled for nonpayment ~~who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment~~ may not reenroll prior to the first day of the month following the payment of an amount equal to two months' premiums.

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

Sec. 14. Minnesota Statutes 2014, section 256L.121, subdivision 1, is amended to read:

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, ~~subdivisions 1 to 32,~~ under which selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

Sec. 15. Minnesota Statutes 2014, section 270A.03, subdivision 5, is amended to read:

Subd. 5. **Debt.** (a) "Debt" means a legal obligation of a natural person to pay a fixed and certain amount of money, which equals or exceeds $25 and which is due and payable to a claimant agency. The term includes criminal fines imposed under section 609.10 or 609.125, fines imposed for petty misdemeanors as defined in section 609.02, subdivision 4a, and restitution. A debt may arise under a contractual or statutory obligation, a court order, or other legal obligation, but need not have been reduced to judgment.

A debt includes any legal obligation of a current recipient of assistance which is based on overpayment of an assistance grant where that payment is based on a client waiver or an administrative or judicial finding of an intentional program violation; or where the debt is owed to a program wherein the debtor is not a client at the time notification is provided to initiate recovery under this chapter and the debtor is not a current recipient of food support, transitional child care, or transitional medical assistance.

(b) A debt does not include any legal obligation to pay a claimant agency for medical care, including hospitalization if the income of the debtor at the time when the medical care was rendered does not exceed the following amount:

(1) for an unmarried debtor, an income of $8,800 or less;

(2) for a debtor with one dependent, an income of $11,270 or less;

(3) for a debtor with two dependents, an income of $13,330 or less;

(4) for a debtor with three dependents, an income of $15,120 or less;

(5) for a debtor with four dependents, an income of $15,950 or less; and

(6) for a debtor with five or more dependents, an income of $16,630 or less.

(c) The commissioner shall adjust the income amounts in paragraph (b) by the percentage determined pursuant to the provisions of section 1(f) of the Internal Revenue Code, except that in section 1(f)(3)(B) the word "1999" shall be substituted for the word "1992." For 2001, the commissioner shall then determine the percent change from the 12 months ending on August 31, 1999, to the 12 months ending on August 31, 2000, and in each subsequent year, from the 12 months ending on August 31, 1999, to the 12 months ending on August 31 of the year preceding the taxable year. The determination of the commissioner pursuant to this subdivision shall not be considered a "rule" and shall not be subject to the Administrative Procedure Act contained in chapter 14. The income amount as adjusted must be rounded to the nearest $10 amount. If the amount ends in $5, the amount is rounded up to the nearest $10 amount.

(d) Debt also includes an agreement to pay a MinnesotaCare premium, regardless of the dollar amount of the premium authorized under Minnesota Statutes 2014, section 256L.15, subdivision 1a.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 16. Minnesota Statutes 2014, section 270B.14, subdivision 1, is amended to read:

Subdivision 1. **Disclosure to commissioner of human services.** (a) On the request of the commissioner of human services, the commissioner shall disclose return information regarding taxes imposed by chapter 290, and claims for refunds under chapter 290A, to the extent provided in paragraph (b) and for the purposes set forth in paragraph (c).

(b) Data that may be disclosed are limited to data relating to the identity, whereabouts, employment, income, and property of a person owing or alleged to be owing an obligation of child support.

(c) The commissioner of human services may request data only for the purposes of carrying out the child support enforcement program and to assist in the location of parents who have, or appear to have, deserted their children. Data received may be used only as set forth in section 256.978.

(d) The commissioner shall provide the records and information necessary to administer the supplemental housing allowance to the commissioner of human services.

(e) At the request of the commissioner of human services, the commissioner of revenue shall electronically match the Social Security numbers and names of participants in the telephone assistance plan operated under sections 237.69 to 237.71, with those of

property tax refund filers, and determine whether each participant's household income is within the eligibility standards for the telephone assistance plan.

(f) The commissioner may provide records and information collected under sections 295.50 to 295.59 to the commissioner of human services for purposes of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234. Upon the written agreement by the United States Department of Health and Human Services to maintain the confidentiality of the data, the commissioner may provide records and information collected under sections 295.50 to 295.59 to the Centers for Medicare and Medicaid Services section of the United States Department of Health and Human Services for purposes of meeting federal reporting requirements.

(g) The commissioner may provide records and information to the commissioner of human services as necessary to administer the early refund of refundable tax credits.

~~(h) The commissioner may disclose information to the commissioner of human services necessary to verify income for eligibility and premium payment under the MinnesotaCare program, under section 256L.05, subdivision 2.~~

~~(i)~~ (h) The commissioner may disclose information to the commissioner of human services necessary to verify whether applicants or recipients for the Minnesota family investment program, general assistance, food support, Minnesota supplemental aid program, and child care assistance have claimed refundable tax credits under chapter 290 and the property tax refund under chapter 290A, and the amounts of the credits.

~~(j)~~ (i) The commissioner may disclose information to the commissioner of human services necessary to verify income for purposes of calculating parental contribution amounts under section 252.27, subdivision 2a.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 17. **REVISOR INSTRUCTION.**

In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall strike references to Minnesota Statutes, chapter 256L, and to statutory sections within that chapter, and shall make all necessary grammatical and conforming changes.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 18. **REPEALER.**

Subdivision 1. **MinnesotaCare program.** Minnesota Statutes 2014, sections 256L.01, subdivisions 1, 1a, 1b, 2, 3, 3a, 5, 6, and 7; 256L.02, subdivisions 1, 2, 3, 5, and 6; 256L.03, subdivisions 1, 1a, 1b, 2, 3, 3a, 3b, 4, 4a, 5, and 6; 256L.04, subdivisions 1,

1a, 1c, 2, 2a, 7, 7a, 7b, 8, 10, 12, 13, and 14; 256L.05, subdivisions 1, 1a, 1b, 1c, 2, 3, 3a, 3c, 4, 5, and 6; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3, and 4; 256L.09, subdivisions 1, 2, 4, 5, 6, and 7; 256L.10; 256L.11, subdivisions 1, 2, 2a, 3, 4, and 7; 256L.12; 256L.121; 256L.15, subdivisions 1, 1a, 1b, and 2; 256L.18; 256L.22; 256L.24; 256L.26; and 256L.28, are repealed.

Subd. 2. **Conforming repealers.** Minnesota Statutes 2014, sections 13.461, subdivision 26; 16A.724, subdivision 3; 62A.046, subdivision 5; and 256.01, subdivision 35, are repealed.

EFFECTIVE DATE. This section is effective January 1, 2016.

ARTICLE 3

MNSURE

Section 1. **EXPANDED ACCESS TO QUALIFIED HEALTH PLANS AND SUBSIDIES.**

The commissioner of commerce, in consultation with the Board of Directors of MNsure and the MNsure Legislative Oversight Committee, shall develop a proposal to allow individuals to purchase qualified health plans outside of MNsure directly from health plan companies and to allow eligible individuals to receive advanced premium tax credits and cost-sharing reductions when purchasing these health plans. The commissioner shall seek all federal waivers and approvals necessary to implement this proposal. The commissioner shall submit a draft proposal to the MNsure board and the MNsure Legislative Oversight Committee at least 30 days before submitting a final proposal to the federal government and shall notify the board and legislative oversight committee of any federal decision or action related to the proposal.

Sec. 2. Minnesota Statutes 2014, section 15A.0815, subdivision 3, is amended to read:

Subd. 3. **Group II salary limits.** The salary for a position listed in this subdivision shall not exceed 120 percent of the salary of the governor. This limit must be adjusted annually on January 1. The new limit must equal the limit for the prior year increased by the percentage increase, if any, in the Consumer Price Index for all urban consumers from October of the second prior year to October of the immediately prior year. The commissioner of management and budget must publish the limit on the department's Web site. This subdivision applies to the following positions:

Executive director of Gambling Control Board;

Commissioner, Iron Range Resources and Rehabilitation Board;

Commissioner, Bureau of Mediation Services;

Ombudsman for Mental Health and Developmental Disabilities;

Chair, Metropolitan Council;

Executive Director, MNsure;

School trust lands director;

Executive director of pari-mutuel racing; and

Commissioner, Public Utilities Commission.

Sec. 3. Minnesota Statutes 2014, section 62A.02, subdivision 2, is amended to read:

Subd. 2. **Approval.** (a) The health plan form shall not be issued, nor shall any application, rider, endorsement, or rate be used in connection with it, until the expiration of 60 days after it has been filed unless the commissioner approves it before that time.

(b) Notwithstanding paragraph (a), a rate filed with respect to a policy of accident and sickness insurance as defined in section 62A.01 by an insurer licensed under chapter 60A, may be used on or after the date of filing with the commissioner. Rates that are not approved or disapproved within the 60-day time period are deemed approved. This paragraph does not apply to Medicare-related coverage as defined in section 62A.3099, subdivision 17.

(c) For coverage to begin on or after January 1, 2016, and each January 1 thereafter, health plans in the individual and small group markets that are not grandfathered plans to be offered outside MNsure and qualified health plans to be offered inside MNsure must receive rate approval from the commissioner no later than 30 days prior to the beginning of the annual open enrollment period for MNsure. Premium rates for all carriers in the applicable market for the next calendar year must be made available to the public by the commissioner only after all rates for the applicable market are final and approved. Final and approved rates must be publicly released at a uniform time for all individual and small group health plans that are not grandfathered plans to be offered outside MNsure and qualified health plans to be offered inside MNsure, and no later than 30 days prior to the beginning of the annual open enrollment period for MNsure.

Sec. 4. Minnesota Statutes 2014, section 62V.02, is amended by adding a subdivision to read:

Subd. 2a. **Consumer assistance partner.** "Consumer assistance partner" means individuals and entities certified by MNsure to serve as a navigator, in-person assister, or certified application counselor.

Sec. 5. Minnesota Statutes 2014, section 62V.03, subdivision 2, is amended to read:

Subd. 2. **Application of other law.** (a) MNsure must be reviewed by the legislative auditor under section 3.971. The legislative auditor shall audit the books, accounts, and affairs of MNsure once each year or less frequently as the legislative auditor's funds and personnel permit. Upon the audit of the financial accounts and affairs of MNsure, MNsure is liable to the state for the total cost and expenses of the audit, including the salaries paid to the examiners while actually engaged in making the examination. The legislative auditor may bill MNsure either monthly or at the completion of the audit. All collections received for the audits must be deposited in the general fund and are appropriated to the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit Commission is requested to direct the legislative auditor to report by March 1, 2014, to the legislature on any duplication of services that occurs within state government as a result of the creation of MNsure. The legislative auditor may make recommendations on consolidating or eliminating any services deemed duplicative. The board shall reimburse the legislative auditor for any costs incurred in the creation of this report.

(b) Board members of MNsure are subject to sections 10A.07 and 10A.09. Board members and the personnel of MNsure are subject to section 10A.071.

(c) All meetings of the board shall comply with the open meeting law in chapter 13D~~, except that:~~.

~~(1) meetings, or portions of meetings, regarding compensation negotiations with the director or managerial staff may be closed in the same manner and according to the same procedures identified in section 13D.03;~~

~~(2) meetings regarding contract negotiation strategy may be closed in the same manner and according to the same procedures identified in section 13D.05, subdivision 3, paragraph (c); and~~

~~(3) meetings, or portions of meetings, regarding not public data described in section 62V.06, subdivision 3, and regarding trade secret information as defined in section 13.37, subdivision 1, paragraph (b), are closed to the public, but must otherwise comply with the procedures identified in chapter 13D.~~

(d) MNsure and provisions specified under this chapter are exempt from~~:~~

~~(1)~~ chapter 14, including section 14.386, except as specified in section 62V.05~~; and~~.

~~(2) chapters 16B and 16C, with the exception of sections 16C.08, subdivision 2, paragraph (b), clauses (1) to (8); 16C.086; 16C.09, paragraph (a), clauses (1) and (3), paragraph (b), and paragraph (c); and section 16C.16. However, MNsure, in consultation with the commissioner of administration, shall implement policies and procedures to establish an open and competitive procurement process for MNsure that, to the extent practicable, conforms to the principles and procedures contained in chapters 16B and 16C.~~

~~In addition, MNsure may enter into an agreement with the commissioner of administration for other services.~~

(e) The board and the Web site are exempt from chapter 60K. Any employee of MNsure who sells, solicits, or negotiates insurance to individuals or small employers must be licensed as an insurance producer under chapter 60K.

(f) Section 3.3005 applies to any federal funds received by MNsure.

~~(g) MNsure is exempt from the following sections in chapter 16E: 16E.01, subdivision 3, paragraph (b); 16E.03, subdivisions 3 and 4; 16E.04, subdivision 1, subdivision 2, paragraph (c), and subdivision 3, paragraph (b); 16E.0465; 16E.055; 16E.145; 16E.15; 16E.16; 16E.17; 16E.18; and 16E.22.~~

~~(h)~~ (g) A MNsure decision that requires a vote of the board, other than a decision that applies only to hiring of employees or other internal management of MNsure, is an "administrative action" under section 10A.01, subdivision 2.

Sec. 6. Minnesota Statutes 2014, section 62V.04, subdivision 1, is amended to read:

Subdivision 1. **Board.** MNsure is governed by a board of directors with ~~seven~~ 11 members.

Sec. 7. Minnesota Statutes 2014, section 62V.04, subdivision 2, is amended to read:

Subd. 2. **Appointment.** (a) Board membership of MNsure consists of the following:

(1) ~~three~~ six members appointed by the governor with the advice and consent of ~~both~~ the senate ~~and the house of representatives acting separately in accordance with paragraph (d)~~, with one member representing the interests of individual consumers eligible for individual market coverage, one member representing individual consumers eligible for public health care program coverage, ~~and~~ one member representing small employers, one member who is an insurance producer, and two members who are county employees involved in the administration of public health care programs. Members are appointed to serve four-year terms following the initial staggered-term lot determination;

(2) three members appointed by the governor with the advice and consent of ~~both~~ the senate ~~and the house of representatives acting separately in accordance with paragraph (d)~~ who have demonstrated expertise, leadership, and innovation in the following areas: one member representing the areas of health administration, health care finance, health plan purchasing, and health care delivery systems; one member representing the areas of public health, health disparities, public health care programs, and the uninsured; and one member representing health policy issues related to the small group and individual markets.

Members are appointed to serve four-year terms following the initial staggered-term lot determination; ~~and~~

(3) the commissioner of human services or a designee; and

(4) the chief information officer of MN.IT Services or a designee.

(b) Section 15.0597 shall apply to all appointments, except for the commissioner.

(c) The governor shall make appointments to the board that are consistent with federal law and regulations regarding its composition and structure. All board members appointed by the governor must be legal residents of Minnesota.

~~(d) Upon appointment by the governor, a board member shall exercise duties of office immediately. If both the house of representatives and the senate vote not to confirm an appointment, the appointment terminates on the day following the vote not to confirm in the second body to vote.~~

~~(e) Initial appointments shall be made by April 30, 2013.~~

~~(f)~~ (d) One of the ~~six~~ nine members appointed under paragraph (a), clause (1) or (2), must have experience in representing the needs of vulnerable populations and persons with disabilities.

~~(g)~~ (e) Membership on the board must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Sec. 8. Minnesota Statutes 2014, section 62V.04, subdivision 4, is amended to read:

Subd. 4. **Conflicts of interest.** (a) Within one year prior to or at any time during their appointed term, board members appointed under subdivision 2, paragraph (a), clauses (1) and (2), shall not be employed by, be a member of the board of directors of, or otherwise be a representative of a health carrier, institutional health care provider or other entity providing health care, navigator, ~~insurance producer,~~ or other entity in the business of selling items or services of significant value to or through MNsure. For purposes of this paragraph, "health care provider or entity" does not include an academic institution.

(b) Board members must recuse themselves from discussion of and voting on an official matter if the board member has a conflict of interest. For board members other than an insurance producer or a county employee, a conflict of interest means an association including a financial or personal association that has the potential to bias or have the appearance of biasing a board member's decisions in matters related to MNsure or the conduct of activities under this chapter. The board member who is an insurance producer and the board members who are county employees are subject to section 10A.07.

(c) No board member shall have a spouse who is an executive of a health carrier.

(d) No member of the board may currently serve as a lobbyist, as defined under section 10A.01, subdivision 21.

Sec. 9. **[62V.045] EXECUTIVE DIRECTOR.**

The governor shall appoint the executive director of MNsure. The executive director serves in the unclassified service at the pleasure of the governor.

Sec. 10. Minnesota Statutes 2014, section 62V.05, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) The board shall operate MNsure according to this chapter and applicable state and federal law.

(b) The board has the power to:

(1) employ personnel, subject to the power of the governor to appoint the executive director, and delegate administrative, operational, and other responsibilities to the director and other personnel as deemed appropriate by the board. This authority is subject to chapters 43A and 179A. The director and managerial staff of MNsure shall serve in the unclassified service ~~and shall be governed by a compensation plan prepared by the board, submitted to the commissioner of management and budget for review and comment within 14 days of its receipt, and approved by the Legislative Coordinating Commission and the legislature under section 3.855, except that section 15A.0815, subdivision 5, paragraph (c), shall not apply~~. The director of MNsure shall not receive a salary increase on or after July 1, 2015, unless the increase is approved under the process specified in section 15A.0815, subdivision 5;

(2) establish the budget of MNsure;

(3) seek and accept money, grants, loans, donations, materials, services, or advertising revenue from government agencies, philanthropic organizations, and public and private sources to fund the operation of MNsure. No health carrier or insurance producer shall advertise on MNsure;

(4) contract for the receipt and provision of goods and services;

(5) enter into information-sharing agreements with federal and state agencies and other entities, provided the agreements include adequate protections with respect to the confidentiality and integrity of the information to be shared, and comply with all applicable state and federal laws, regulations, and rules, including the requirements of section 62V.06; and

(6) exercise all powers reasonably necessary to implement and administer the requirements of this chapter and the Affordable Care Act, Public Law 111-148.

(c) The board shall establish policies and procedures to gather public comment and provide public notice in the State Register.

(d) Within 180 days of enactment, the board shall establish bylaws, policies, and procedures governing the operations of MNsure in accordance with this chapter.

Sec. 11. Minnesota Statutes 2014, section 62V.05, subdivision 5, is amended to read:

Subd. 5. **Health carrier and health plan requirements; MNsure participation.** ~~(a) Beginning January 1, 2015, the board may establish certification requirements for health carriers and health plans to be offered through MNsure that satisfy federal requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.~~

~~(b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory requirements that:~~

~~(1) apply uniformly to all health carriers and health plans in the individual market;~~

~~(2) apply uniformly to all health carriers and health plans in the small group market; and~~

~~(3) satisfy minimum federal certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.~~

~~(c) In accordance with section 1311(c) of the Affordable Care Act, Public Law 111-148, the board shall establish policies and procedures for certification and selection of health plans to be offered as qualified health plans through MNsure. The board shall certify and select a health plan as a qualified health plan to be offered through MNsure, if:~~

~~(1) the health plan meets the minimum certification requirements established in paragraph (a) or the market regulatory requirements in paragraph (b);~~

~~(2) the board determines that making the health plan available through MNsure is in the interest of qualified individuals and qualified employers;~~

~~(3) the health carrier applying to offer the health plan through MNsure also applies to offer health plans at each actuarial value level and service area that the health carrier currently offers in the individual and small group markets; and~~

~~(4) the health carrier does not apply to offer health plans in the individual and small group markets through MNsure under a separate license of a parent organization or holding company under section 60D.15, that is different from what the health carrier offers in the individual and small group markets outside MNsure.~~

~~(d) In determining the interests of qualified individuals and employers under paragraph (c), clause (2), the board may not exclude a health plan for any reason specified under section 1311(c)(1)(B) of the Affordable Care Act, Public Law 111-148. The board may consider:~~

~~(1) affordability;~~

~~(2) quality and value of health plans;~~

~~(3) promotion of prevention and wellness;~~

~~(4) promotion of initiatives to reduce health disparities;~~

~~(5) market stability and adverse selection;~~

~~(6) meaningful choices and access;~~

~~(7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and~~

~~(8) other criteria that the board determines appropriate.~~

~~(c) For qualified health plans offered through MNsure on or after January 1, 2015, the board shall establish policies and procedures under paragraphs (c) and (d) for selection of health plans to be offered as qualified health plans through MNsure by February 1 of each year, beginning February 1, 2014. The board shall consistently and uniformly apply all policies and procedures and any requirements, standards, or criteria to all health carriers and health plans. For any policies, procedures, requirements, standards, or criteria that are defined as rules under section 14.02, subdivision 4, the board may use the process described in subdivision 9.~~

~~(f) For 2014, the board shall not have the power to select health carriers and health plans for participation in MNsure. The board shall permit all health plans that meet the certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, to be offered through MNsure.~~

(a) The board shall permit all health plans that meet the applicable certification requirements to be offered through MNsure.

~~(g)~~ (b) Under this subdivision, the board shall have the power to verify that health carriers and health plans are properly certified to be eligible for participation in MNsure.

~~(h)~~ (c) The board has the authority to decertify health carriers and health plans that fail to maintain compliance with section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

~~(i)~~ (d) For qualified health plans offered through MNsure beginning January 1, 2015, health carriers must use the most current addendum for Indian health care providers approved by the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with Indian health care providers. MNsure shall comply with all future changes in federal law with regard to health coverage for the tribes.

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 12. Minnesota Statutes 2014, section 62V.05, subdivision 6, is amended to read:

Subd. 6. **Appeals.** (a) The board may conduct hearings, appoint hearing officers, and recommend final orders related to appeals of any MNsure determinations, except for those determinations identified in paragraph (d). An appeal by a health carrier regarding a specific certification ~~or selection~~ determination made by MNsure under subdivision 5 must be conducted as a contested case proceeding under chapter 14, with the report or order of the administrative law judge constituting the final decision in the case, subject to judicial review under sections 14.63 to 14.69. For other appeals, the board shall establish hearing processes which provide for a reasonable opportunity to be heard and timely resolution of the appeal and which are consistent with the requirements of federal law and guidance. An appealing party may be represented by legal counsel at these hearings, but this is not a requirement.

(b) MNsure may establish service-level agreements with state agencies to conduct hearings for appeals. Notwithstanding section 471.59, subdivision 1, a state agency is authorized to enter into service-level agreements for this purpose with MNsure.

(c) For proceedings under this subdivision, MNsure may be represented by an attorney who is an employee of MNsure.

(d) This subdivision does not apply to appeals of determinations where a state agency hearing is available under section 256.045.

Sec. 13. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision to read:

Subd. 11. **Health carrier notification.** MNsure shall provide a health carrier with enrollment information for MNsure enrollees who have selected a qualified health plan that is offered by that health carrier and who have been determined by MNsure to be eligible for qualified health plan coverage. The enrollment information must be sufficient for the health carrier to issue coverage and must be provided within 48 hours of the determination of eligibility by MNsure.

Sec. 14. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision to read:

Subd. 12. **Purchase of individual health coverage.** For coverage taking effect on or after January 1, 2016, the MNsure board shall provide members of a household with the option of purchasing individual health coverage through MNsure and shall apportion any advanced premium tax credit available to a household choosing this option between the separate health plans providing coverage to the household members.

Sec. 15. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision to read:

Subd. 13. **Prohibition on other product lines.** MNsure is prohibited from certifying, selecting, or offering products and policies of coverage that do not meet the definition of health plan or dental plan as provided in section 62V.02.

Sec. 16. Minnesota Statutes 2014, section 62V.11, subdivision 2, is amended to read:

Subd. 2. **Membership; meetings; compensation.** (a) The Legislative Oversight Committee shall consist of five members of the senate, three members appointed by the majority leader of the senate, and two members appointed by the minority leader of the senate; and five members of the house of representatives, three members appointed by the speaker of the house, and two members appointed by the minority leader of the house of representatives.

(b) Appointed legislative members serve at the pleasure of the appointing authority and shall continue to serve until their successors are appointed.

(c) The first meeting of the committee shall be convened by the chair of the Legislative Coordinating Commission. Members shall elect a chair at the first meeting. The chair must convene at least one meeting ~~annually~~ each quarter of the year, and may convene other meetings as deemed necessary.

Sec. 17. Minnesota Statutes 2014, section 62V.11, is amended by adding a subdivision to read:

Subd. 5. **Reports to the committee.** (a) The board shall submit an enrollment report to the Legislative Oversight Committee on a monthly basis. The report must include:

(1) total enrollment numbers;

(2) the number of commercial plans selected;

(3) the percentage of the commercial plans for which the first month's premium has been paid; and

(4) the average number of days between a consumer's submission of an application and transmittal to the health carrier chosen.

(b) At each of the committee's quarterly meetings, the board shall present the following information:

(1) at the first quarterly meeting, a progress report on the most recent MNsure open enrollment period and a progress report on technology upgrades and any proposed schedule for future technology upgrades;

(2) at the second quarterly meeting, the annual budget for MNsure, as required by subdivision 4;

(3) at the third quarterly meeting, a hearing in conjunction with the Department of Human Services regarding any backlog created by qualifying life events for enrollees in public or private health plans through MNsure; and

(4) at the fourth quarterly meeting, a hearing in conjunction with the Department of Commerce on the release of premium rates and in conjunction with the Department of Human Services on reimbursement of MNsure for public program enrollment.

Sec. 18. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision to read:

Subd. 10. **MNsure consumer assistance partners.** Effective January 1, 2016, the commissioner shall conduct background studies on any individual required under section 256.962, subdivision 9, to have a background study completed under this chapter.

Sec. 19. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision to read:

Subd. 11. **MNsure consumer assistance partners.** The commissioner shall recover the cost of background studies required under section 256.962, subdivision 9, through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 20. Minnesota Statutes 2014, section 256.962, is amended by adding a subdivision to read:

Subd. 9. **Background studies for consumer assistance partners.** Effective January 1, 2016, all consumer assistance partners, as defined in section 62V.02, subdivision 2a, are required to undergo a background study according to the requirements of chapter 245C.

Sec. 21. **TRANSITION.**

(a) The commissioner of management and budget must assign the positions of managerial employees of MNsure, other than the director, to salary ranges and salaries in the managerial plan, effective the first payroll period beginning on or after July 1, 2015.

(b) Of the four additional members of the board appointed under the amendments to Minnesota Statutes, section 62V.04, one shall have an initial term of two years, two shall have an initial term of three years, and one shall have an initial term of four years, determined by lot by the secretary of state.

(c) Board members must be appointed by the governor within 30 days of final enactment of these sections.

Sec. 22. **EXPANDED ACCESS TO THE SMALL BUSINESS HEALTH CARE TAX CREDIT.**

(a) The commissioner of human services, in consultation with the Board of Directors of MNsure and the MNsure Legislative Oversight Committee, shall develop a proposal to allow small employers the ability to receive the small business health care tax credit when the small employer pays the premiums on behalf of employees enrolled in either a qualified health plan offered through a small business health options program (SHOP) marketplace or a small group health plan offered outside of the SHOP marketplace within MNsure. To be eligible for the tax credit, the small employer must meet the requirements under the Affordable Care Act, except that employees may be enrolled in a small group health plan product offered outside of MNsure.

(b) The commissioner shall seek all federal waivers and approvals necessary to implement the proposal in paragraph (a). The commissioner shall submit a draft proposal to the MNsure board and the MNsure Legislative Oversight Committee at least 30 days before submitting a final proposal to the federal government, and shall notify the board and Legislative Oversight Committee of any federal decision or action received regarding the proposal and submitted waiver.

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

Sec. 23. **CONFIRMATION DEADLINE.**

Members of the MNsure Board on the effective date of this section and new members appointed as required by the amendments to Minnesota Statutes, section 62V.04, are subject to confirmation by the senate. If any of these members is not confirmed by the senate before adjournment sine die of the 2016 regular session, the appointment of that member to the board terminates on the day following adjournment sine die.

Sec. 24. **ESTABLISHMENT OF FEDERALLY FACILITATED MARKETPLACE.**

Subdivision 1. **Establishment.** The commissioner of commerce, in cooperation with the secretary of Health and Human Services, shall establish a federally facilitated marketplace for Minnesota, for coverage beginning January 1, 2017. The federally facilitated marketplace shall take the place of MNsure, established under Minnesota

Statutes, chapter 62V. In working with the secretary of Health and Human Services to develop the federally facilitated marketplace, the commissioner of commerce shall:

(1) seek to incorporate, where appropriate and cost-effective, elements of the MNsure eligibility determination system;

(2) regularly consult with stakeholder groups, including but not limited to representatives of state agencies, health care providers, health plan companies, brokers, and consumers; and

(3) seek all available federal grants and funds for state planning and development costs.

Subd. 2. **Implementation plan; draft legislation.** The commissioner of commerce, in consultation with the commissioner of human services, the chief information officer of MN.IT, and the MNsure Board, shall develop and present to the 2016 legislature an implementation plan for conversion to a federally facilitated marketplace. The plan must include draft legislation for any changes in state law necessary to implement a federally facilitated marketplace, including but not limited to necessary changes to Laws 2013, chapter 84, and technical and conforming changes related to the repeal of Minnesota Statutes, chapter 62V.

Subd. 3. **Vendor contract.** The commissioner of commerce, in consultation with the commissioner of human services, the chief information officer of MN.IT, and the MNsure Board, shall contract with a vendor to provide technical assistance in developing and implementing the plan for conversion to a federally facilitated marketplace.

Subd. 4. **Contingent implementation.** The commissioner shall not implement this section if the United States Supreme Court rules in King v. Burwell (No. 14-114) that persons obtaining qualified health plan coverage through a federally facilitated marketplace are not eligible for advanced premium tax credits.

Sec. 25. **REQUIREMENTS FOR STATE MATCH FOR FEDERAL GRANTS.**

(a) The legislature shall not appropriate or authorize the use of state funds, and the MNsure Board and the commissioner of human services shall not allocate, authorize the use of, or expend board or agency funds, as a state match to obtain federal grant funding for MNsure, including, but not limited to, grants to support the development and operation of the MNsure eligibility determination system, unless the following conditions are met:

(1) 20 percent of the state match and 20 percent of federal grant funds received are deposited into a premium reimbursement account established by the MNsure Board, for use as provided in paragraph (b);

(2) the commissioner of human services and the legislative auditor have verified that all persons currently enrolled in medical assistance and MinnesotaCare, who were enrolled in medical assistance or MinnesotaCare as of September 30, 2013, have had their eligibility for the program redetermined at least once since September 30, 2013;

(3) the administrative costs of MNsure are less than five percent of MNsure's total operating budget in each year; and

(4) verification from the Office of the Legislative Auditor that:

(i) all life events or changes in circumstances are being processed in a timely manner by MNsure and the Department of Human Services; and

(ii) MNsure is transmitting electronic enrollment files in a format that conforms with standards under the federal Health Insurance Portability and Accountability Act of 1996.

(b) Funds deposited into the premium reimbursement account shall be used only to reimburse the first month's premium for health coverage for any individual who submitted a complete application for qualified health plan coverage through MNsure, but did not receive their policy card or other appropriate verification of coverage within 20 days of submittal of the completed application to MNsure. The MNsure Board shall provide this reimbursement on a first-come, first-served basis, subject to the limits of available funding.

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

Sec. 26. **REPEALER.**

(a) Minnesota Statutes 2014, sections 62V.01; 62V.02; 62V.03; 62V.04; 62V.05; 62V.06; 62V.07; 62V.08; 62V.09; 62V.10; and 62V.11, are repealed, effective January 1, 2017. This repealer shall not take effect if the United States Supreme Court rules in King v. Burwell (No. 14-114) that persons obtaining qualified health plan coverage through a federally facilitated marketplace are not eligible for advanced premium tax credits.

(b) Minnesota Statutes 2014, section 13D.08, subdivision 5a, is repealed.

ARTICLE 4

CONTINUING CARE

Section 1. Minnesota Statutes 2014, section 13.461, is amended by adding a subdivision to read:

Subd. 32. **ABLE accounts and designated beneficiaries.** Data on ABLE accounts and designated beneficiaries of ABLE accounts are classified under section 256Q.05, subdivision 7.

Sec. 2. Minnesota Statutes 2014, section 245A.06, is amended by adding a subdivision to read:

Subd. 1a. **Correction orders and conditional licenses for programs licensed as home and community-based services.** (a) For programs licensed under both this chapter and chapter 245D, if the license holder operates more than one service site under a single license governed by chapter 245D, the order issued under this section shall be specific to the service site or sites at which the violations of applicable law or rules occurred. The order shall not apply to other service sites governed by chapter 245D and operated by the same license holder unless the commissioner has included in the order the articulable basis for applying the order to another service site.

(b) If the commissioner has issued more than one license to the license holder under this chapter, the conditions imposed under this section shall be specific to the license for the program at which the violations of applicable law or rules occurred and shall not apply to other licenses held by the same license holder if those programs are being operated in substantial compliance with applicable law and rules.

Sec. 3. **[245A.081] SETTLEMENT AGREEMENT.**

(a) A license holder who has made a timely appeal pursuant to section 245A.06, subdivision 4, or 245A.07, subdivision 3, or the commissioner may initiate a discussion about a possible settlement agreement related to the licensing sanction. For the purposes of this section, the following conditions apply to a settlement agreement reached by the parties:

(1) if the parties enter into a settlement agreement, the effect of the agreement shall be that the appeal is withdrawn and the agreement shall constitute the full agreement between the commissioner and the party who filed the appeal; and

(2) the settlement agreement must identify the agreed upon actions the license holder has taken and will take in order to achieve and maintain compliance with the licensing requirements that the commissioner determined the license holder had violated.

(b) Neither the license holder nor the commissioner is required to initiate a settlement discussion under this section.

(c) If a settlement discussion is initiated by the license holder, the commissioner shall respond to the license holder within 14 calendar days of receipt of the license holder's submission.

(d) If the commissioner agrees to engage in settlement discussions, the commissioner may decide at any time not to continue settlement discussions with a license holder.

Sec. 4. Minnesota Statutes 2014, section 245A.155, subdivision 1, is amended to read:

Subdivision 1. **Licensed foster care and respite care.** This section applies to foster care agencies and licensed foster care providers who place, supervise, or care for individuals who rely on medical monitoring equipment to sustain life or monitor a medical condition that could become life-threatening without proper use of the medical equipment in respite care or foster care.

Sec. 5. Minnesota Statutes 2014, section 245A.155, subdivision 2, is amended to read:

Subd. 2. **Foster care agency requirements.** In order for an agency to place an individual who relies on medical equipment to sustain life or monitor a medical condition that could become life-threatening without proper use of the medical equipment with a foster care provider, the agency must ensure that the foster care provider has received the training to operate such equipment as observed and confirmed by a qualified source, and that the provider:

(1) is currently caring for an individual who is using the same equipment in the foster home; or

(2) has written documentation that the foster care provider has cared for an individual who relied on such equipment within the past six months; or

(3) has successfully completed training with the individual being placed with the provider.

Sec. 6. Minnesota Statutes 2014, section 245A.65, subdivision 2, is amended to read:

Subd. 2. **Abuse prevention plans.** All license holders shall establish and enforce ongoing written program abuse prevention plans and individual abuse prevention plans as required under section 626.557, subdivision 14.

(a) The scope of the program abuse prevention plan is limited to the population, physical plant, and environment within the control of the license holder and the location where licensed services are provided. In addition to the requirements in section 626.557, subdivision 14, the program abuse prevention plan shall meet the requirements in clauses (1) to (5).

(1) The assessment of the population shall include an evaluation of the following factors: age, gender, mental functioning, physical and emotional health or behavior of the client; the need for specialized programs of care for clients; the need for training of staff to meet identified individual needs; and the knowledge a license holder may have regarding previous abuse that is relevant to minimizing risk of abuse for clients.

(2) The assessment of the physical plant where the licensed services are provided shall include an evaluation of the following factors: the condition and design of the building as it relates to the safety of the clients; and the existence of areas in the building which are difficult to supervise.

(3) The assessment of the environment for each facility and for each site when living arrangements are provided by the agency shall include an evaluation of the following factors: the location of the program in a particular neighborhood or community; the type of grounds and terrain surrounding the building; the type of internal programming; and the program's staffing patterns.

(4) The license holder shall provide an orientation to the program abuse prevention plan for clients receiving services. If applicable, the client's legal representative must be notified of the orientation. The license holder shall provide this orientation for each new person within 24 hours of admission, or for persons who would benefit more from a later orientation, the orientation may take place within 72 hours.

(5) The license holder's governing body or the governing body's delegated representative shall review the plan at least annually using the assessment factors in the plan and any substantiated maltreatment findings that occurred since the last review. The governing body or the governing body's delegated representative shall revise the plan, if necessary, to reflect the review results.

(6) A copy of the program abuse prevention plan shall be posted in a prominent location in the program and be available upon request to mandated reporters, persons receiving services, and legal representatives.

(b) In addition to the requirements in section 626.557, subdivision 14, the individual abuse prevention plan shall meet the requirements in clauses (1) and (2).

(1) The plan shall include a statement of measures that will be taken to minimize the risk of abuse to the vulnerable adult when the individual assessment required in section 626.557, subdivision 14, paragraph (b), indicates the need for measures in addition to the specific measures identified in the program abuse prevention plan. The measures shall include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services, and will identify referrals made when the vulnerable adult is susceptible to abuse outside the scope or control of the licensed services. When the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, the individual abuse prevention plan shall document this determination.

(2) An individual abuse prevention plan shall be developed for each new person as part of the initial individual program plan or service plan required under the applicable

licensing rule. The review and evaluation of the individual abuse prevention plan shall be done as part of the review of the program plan or service plan. The person receiving services shall participate in the development of the individual abuse prevention plan to the full extent of the person's abilities. If applicable, the person's legal representative shall be given the opportunity to participate with or for the person in the development of the plan. The interdisciplinary team shall document the review of all abuse prevention plans at least annually, using the individual assessment and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.

Sec. 7. Minnesota Statutes 2014, section 245D.02, is amended by adding a subdivision to read:

Subd. 37. **Working day.** "Working day" means Monday, Tuesday, Wednesday, Thursday, or Friday, excluding any legal holiday.

Sec. 8. Minnesota Statutes 2014, section 245D.05, subdivision 1, is amended to read:

Subdivision 1. **Health needs.** (a) The license holder is responsible for meeting health service needs assigned in the coordinated service and support plan or the coordinated service and support plan addendum, consistent with the person's health needs. Unless directed otherwise in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder is responsible for promptly notifying the person's legal representative, if any, and the case manager of changes in a person's physical and mental health needs affecting health service needs assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, when discovered by the license holder, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

(b) If responsibility for meeting the person's health service needs has been assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow in order to:

(1) provide medication setup, assistance, or administration according to this chapter. Unlicensed staff responsible for medication setup or medication administration under this section must complete training according to section 245D.09, subdivision 4a, paragraph (d);

(2) monitor health conditions according to written instructions from a licensed health professional;

(3) assist with or coordinate medical, dental, and other health service appointments; or

(4) use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.

Sec. 9. Minnesota Statutes 2014, section 245D.05, subdivision 2, is amended to read:

Subd. 2. **Medication administration.** (a) For purposes of this subdivision, "medication administration" means:

(1) checking the person's medication record;

(2) preparing the medication as necessary;

(3) administering the medication or treatment to the person;

(4) documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and

(5) reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

(b)(1) If responsibility for medication administration is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must implement medication administration procedures to ensure a person takes medications and treatments as prescribed. The license holder must ensure that the requirements in clauses (2) and (3) have been met before administering medication or treatment.

(2) The license holder must obtain written authorization from the person or the person's legal representative to administer medication or treatment ~~and must obtain reauthorization annually as needed~~. This authorization shall remain in effect unless it is withdrawn in writing and may be withdrawn at any time. If the person or the person's legal representative refuses to authorize the license holder to administer medication, the medication must not be administered. The refusal to authorize medication administration must be reported to the prescriber as expediently as possible.

(3) For a license holder providing intensive support services, the medication or treatment must be administered according to the license holder's medication administration policy and procedures as required under section 245D.11, subdivision 2, clause (3).

(c) The license holder must ensure the following information is documented in the person's medication administration record:

(1) the information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes the person's name,

description of the medication or treatment to be provided, and the frequency and other information needed to safely and correctly administer the medication or treatment to ensure effectiveness;

(2) information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;

(3) the possible consequences if the medication or treatment is not taken or administered as directed;

(4) instruction on when and to whom to report the following:

(i) if a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person; and

(ii) the occurrence of possible adverse reactions to the medication or treatment;

(5) notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and

(6) notation of when a medication or treatment is started, administered, changed, or discontinued.

Sec. 10. Minnesota Statutes 2014, section 245D.06, subdivision 1, is amended to read:

Subdivision 1. **Incident response and reporting.** (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person.

(b) The license holder must maintain information about and report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless the license holder has reason to know that the incident has already been reported, or as otherwise directed in a person's coordinated service and support plan or coordinated service and support plan addendum. An incident of suspected or alleged maltreatment must be reported as required under paragraph (d), and an incident of serious injury or death must be reported as required under paragraph (e).

(c) When the incident involves more than one person, the license holder must not disclose personally identifiable information about any other person when making the report to each person and case manager unless the license holder has the consent of the person.

(d) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment. The license holder must disclose the nature of the activity or occurrence reported and the agency that received the report.

(e) The license holder must report the death or serious injury of the person as required in paragraph (b) and to the Department of Human Services Licensing Division, and the Office of Ombudsman for Mental Health and Developmental Disabilities as required under section 245.94, subdivision 2a, within 24 hours of the death or serious injury, or receipt of information that the death or serious injury occurred, unless the license holder has reason to know that the death or serious injury has already been reported.

(f) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to the Department of Health, Office of Health Facility Complaints, and the Office of Ombudsman for Mental Health and Developmental Disabilities, as required under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to know that the death or serious injury has already been reported.

(g) The license holder must conduct an internal review of incident reports of deaths and serious injuries that occurred while services were being provided and that were not reported by the program as alleged or suspected maltreatment, for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. The review must include an evaluation of whether related policies and procedures were followed, whether the policies and procedures were adequate, whether there is a need for additional staff training, whether the reported event is similar to past events with the persons or the services involved, and whether there is a need for corrective action by the license holder to protect the health and safety of persons receiving services. Based on the results of this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

(h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061 or successor provisions.

Sec. 11. Minnesota Statutes 2014, section 245D.06, subdivision 2, is amended to read:

Subd. 2. **Environment and safety.** The license holder must:

(1) ensure the following when the license holder is the owner, lessor, or tenant of the service site:

(i) the service site is a safe and hazard-free environment;

(ii) that toxic substances or dangerous items are inaccessible to persons served by the program only to protect the safety of a person receiving services when a known safety threat exists and not as a substitute for staff supervision or interactions with a person who is receiving services. If toxic substances or dangerous items are made inaccessible, the license holder must document an assessment of the physical plant, its environment, and its population identifying the risk factors which require toxic substances or dangerous items to be inaccessible and a statement of specific measures to be taken to minimize the safety risk to persons receiving services and to restore accessibility to all persons receiving services at the service site;

(iii) doors are locked from the inside to prevent a person from exiting only when necessary to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with the person. If doors are locked from the inside, the license holder must document an assessment of the physical plant, the environment and the population served, identifying the risk factors which require the use of locked doors, and a statement of specific measures to be taken to minimize the safety risk to persons receiving services at the service site; and

(iv) a staff person is available at the service site who is trained in basic first aid and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, cardiopulmonary resuscitation (CPR) whenever persons are present and staff are required to be at the site to provide direct support service. The CPR training must include ~~in-person~~ instruction, hands-on practice, and an observed skills assessment under the direct supervision of a CPR instructor;

(2) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition when used to provide services;

(3) follow procedures to ensure safe transportation, handling, and transfers of the person and any equipment used by the person, when the license holder is responsible for transportation of a person or a person's equipment;

(4) be prepared for emergencies and follow emergency response procedures to ensure the person's safety in an emergency; and

(5) follow universal precautions and sanitary practices, including hand washing, for infection prevention and control, and to prevent communicable diseases.

Sec. 12. Minnesota Statutes 2014, section 245D.06, subdivision 7, is amended to read:

Subd. 7. **Permitted actions and procedures.** (a) Use of the instructional techniques and intervention procedures as identified in paragraphs (b) and (c) is permitted when used on an intermittent or continuous basis. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum as identified in sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

(b) Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:

(1) to calm or comfort a person by holding that person with no resistance from that person;

(2) to protect a person known to be at risk of injury due to frequent falls as a result of a medical condition;

(3) to facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration;

(4) to block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff; or

(5) to redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

(c) Restraint may be used as an intervention procedure to:

(1) allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional ~~to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition~~;

(2) assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm; or

(3) position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.

Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in subdivision 6, paragraph (b).

(d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

Sec. 13. Minnesota Statutes 2014, section 245D.07, subdivision 2, is amended to read:

Subd. 2. **Service planning requirements for basic support services.** (a) License holders providing basic support services must meet the requirements of this subdivision.

(b) Within 15 calendar days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(c) Within 60 calendar days of service initiation the license holder must review and revise as needed the preliminary coordinated service and support plan addendum to document the services that will be provided including how, when, and by whom services will be provided, and the person responsible for overseeing the delivery and coordination of services.

(d) The license holder must participate in service planning and support team meetings for the person following stated timelines established in the person's coordinated service and support plan or as requested by the person or the person's legal representative, the support team or the expanded support team.

Sec. 14. Minnesota Statutes 2014, section 245D.071, subdivision 5, is amended to read:

Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the service plan and the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. The license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in service plan review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year. The purpose of the service plan review is to determine whether changes are needed to the service plan based on the assessment information, the license holder's evaluation of progress towards accomplishing outcomes, or other information provided by the support team or expanded support team.

(b) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a ~~written~~ report ~~sent to the person or the person's legal representative and case manager five working days prior to the review meeting, unless the person, the person's legal representative, or the case manager requests to receive the report~~

available at the time of the progress review meeting. The report must be sent at least five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum.

(c) The license holder must send the coordinated service and support plan addendum to the person, the person's legal representative, and the case manager by mail within ten working days of the progress review meeting. Within ten working days of the ~~progress review meeting~~ mailing of the coordinated service and support plan addendum, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

(d) If, within ten working days of submitting changes to the coordinated service and support plan and coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the coordinated service and support plan or coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan addendum.

Sec. 15. Minnesota Statutes 2014, section 245D.09, subdivision 3, is amended to read:

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education relevant to the primary disability of the person and to meet the person's needs and additional requirements as written in the coordinated service and support plan or coordinated service and support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and to the primary disability of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the coordinated service and support plan or coordinated service and support plan addendum;

(2) demonstrated competency in the orientation and training areas required under this chapter, and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in

these areas is determined by the license holder through knowledge testing or observed skill assessment conducted by the trainer or instructor or by an individual who has been previously deemed competent by the trainer or instructor in the area being assessed; and

(3) except for a license holder who is the sole direct support staff, periodic performance evaluations completed by the license holder of the direct support staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties or administer medication.

Sec. 16. Minnesota Statutes 2014, section 245D.09, subdivision 5, is amended to read:

Subd. 5. **Annual training.** A license holder must provide annual training to direct support staff on the topics identified in subdivision 4, clauses (3) to (10). If the direct support staff has a first aid certification, annual training under subdivision 4, clause (9), is not required as long as the certification remains current. A license holder must provide a minimum of 24 hours of annual training to direct service staff providing intensive services and having fewer than five years of documented experience and 12 hours of annual training to direct service staff providing intensive services and having five or more years of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a) to (f). Training on relevant topics received from sources other than the license holder may count toward training requirements. A license holder must provide a minimum of 12 hours of annual training to direct service staff providing basic services and having fewer than five years of documented experience and six hours of annual training to direct service staff providing basic services and having five or more years of documented experience.

Sec. 17. Minnesota Statutes 2014, section 245D.22, subdivision 4, is amended to read:

Subd. 4. **First aid must be available on site.** (a) A staff person trained in first aid must be available on site and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, be able to provide cardiopulmonary resuscitation, whenever persons are present and staff are required to be at the site to provide direct service. The CPR training must include ~~in-person~~ instruction, hands-on practice, and an observed skills assessment under the direct supervision of a CPR instructor.

(b) A facility must have first aid kits readily available for use by, and that meet the needs of, persons receiving services and staff. At a minimum, the first aid kit must be equipped with accessible first aid supplies including bandages, sterile compresses,

scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, and first aid manual.

Sec. 18. Minnesota Statutes 2014, section 245D.31, subdivision 3, is amended to read:

Subd. 3. **Staff ratio requirement for each person receiving services.** The case manager, in consultation with the interdisciplinary team, must determine at least once each year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio assigned each person and the documentation of how the ratio was arrived at must be kept in each person's individual service plan. Documentation must include an assessment of the person with respect to the characteristics in subdivisions 4, 5, and 6 ~~recorded on a standard assessment form required by the commissioner~~.

Sec. 19. Minnesota Statutes 2014, section 245D.31, subdivision 4, is amended to read:

Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a staff ratio requirement of one to four if:

(1) on a daily basis the person requires total care and monitoring or constant hand-over-hand physical guidance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, or ambulating; ~~or is not capable of taking appropriate action for self-preservation under emergency conditions;~~ or

(2) the person engages in conduct that poses an imminent risk of physical harm to self or others at a documented level of frequency, intensity, or duration requiring frequent daily ongoing intervention and monitoring as established in the person's coordinated service and support plan or coordinated service and support plan addendum.

Sec. 20. Minnesota Statutes 2014, section 245D.31, subdivision 5, is amended to read:

Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a staff ratio requirement of one to eight if:

(1) the person does not meet the requirements in subdivision 4; and

(2) on a daily basis the person requires verbal prompts or spot checks and minimal or no physical assistance to successfully complete at least ~~four~~ three of the following activities: toileting, communicating basic needs, eating, or ambulating~~, or taking appropriate action for self-preservation under emergency conditions~~.

Sec. 21. Minnesota Statutes 2014, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~2.48~~ 2.23 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to ~~6.75~~ 6.08 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be ~~6.75~~ 6.08 percent of adjusted gross income;

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~6.75~~ 6.08 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~nine~~ 8.1 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be ~~11.25~~ 10.13 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this

section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a

benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 22. Minnesota Statutes 2014, section 256.478, is amended to read:

256.478 HOME AND COMMUNITY-BASED SERVICES TRANSITIONS GRANTS.

~~(a)~~ The commissioner shall make available home and community-based services transition grants to serve individuals who do not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

~~(b) For the purposes of this section, the commissioner has the authority to transfer funds between the medical assistance account and the home and community-based services transitions grants account.~~

Sec. 23. Minnesota Statutes 2014, section 256.975, subdivision 2, is amended to read:

Subd. 2. **Duties.** The ~~board~~ Minnesota Board on Aging shall carry out the following duties:

(1) to advise the governor and heads of state departments and agencies regarding policy, programs, and services affecting the aging;

(2) to provide a mechanism for coordinating plans and activities of state departments and citizens' groups as they pertain to aging;

(3) to create public awareness of the special needs and potentialities of older persons;

(4) to gather and disseminate information about research and action programs, and to encourage state departments and other agencies to conduct needed research in the field of aging;

(5) to stimulate, guide, and provide technical assistance in the organization of local councils on aging;

(6) to provide continuous review of ongoing services, programs and proposed legislation affecting the elderly in Minnesota;

(7) to administer and to make policy relating to all aspects of the Older Americans Act of 1965, as amended, including implementation thereof; ~~and~~

(8) to award grants, enter into contracts, and adopt rules the Minnesota Board on Aging deems necessary to carry out the purposes of this section~~.~~;

(9) develop the criteria and procedures to allocate the grants under subdivision 11, evaluate all applications on a competitive basis and award the grants, and select qualified providers to offer technical assistance to grant applicants and grantees. The selected provider shall provide applicants and grantees assistance with project design, evaluation methods, materials, and training; and

(10) submit by January 15, 2017, and on each January 15 thereafter, a progress report on the dementia grants programs under subdivision 11 to the chairs and ranking minority members of the senate and house of representatives committees and divisions with jurisdiction over health finance and policy. The report shall include:

(i) information on each grant recipient;

(ii) a summary of all projects or initiatives undertaken with each grant;

(iii) the measurable outcomes established by each grantee, an explanation of the evaluation process used to determine whether the outcomes were met, and the results of the evaluation;

(iv) an accounting of how the grant funds were spent; and

(v) the overall impact of the projects and initiatives that were conducted.

Sec. 24. Minnesota Statutes 2014, section 256.975, is amended by adding a subdivision to read:

Subd. 11. **Regional and local dementia grants.** (a) The Minnesota Board on Aging shall award competitive grants to eligible applicants for regional and local projects and initiatives targeted to a designated community, which may consist of a specific geographic area or population, to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, or connect caregivers of persons with dementia to education and resources.

(b) The project areas for grants include:

(1) local or community-based initiatives to promote the benefits of physician consultations for all individuals who suspect a memory or cognitive problem;

(2) local or community-based initiatives to promote the benefits of early diagnosis of Alzheimer's disease and other dementias; and

(3) local or community-based initiatives to provide informational materials and other resources to caregivers of persons with dementia.

(c) Eligible applicants for local and regional grants may include, but are not limited to, community health boards, school districts, colleges and universities, community clinics, tribal communities, nonprofit organizations, and other health care organizations.

(d) Applicants must submit proposals for available grants to the Minnesota Board on Aging by September 1, 2015, and each September 1 thereafter. The application must:

(1) describe the proposed initiative, including the targeted community and how the initiative meets the requirements of this subdivision; and

(2) identify the proposed outcomes of the initiative and the evaluation process to be used to measure these outcomes.

(e) In awarding the regional and local dementia grants, the Minnesota Board on Aging must give priority to applicants who demonstrate that the proposed project:

(1) is supported by and appropriately targeted to the community the applicant serves;

(2) is designed to coordinate with other community activities related to other health initiatives, particularly those initiatives targeted at the elderly;

(3) is conducted by an applicant able to demonstrate expertise in the project areas;

(4) utilizes and enhances existing activities and resources or involves innovative approaches to achieve success in the project areas; and

(5) strengthens community relationships and partnerships in order to achieve the project areas.

(f) The board shall divide the state into specific geographic regions and allocate a percentage of the money available for the local and regional dementia grants to projects or initiatives aimed at each geographic region.

(g) The board shall award any available grants by October 1, 2015, and each October 1 thereafter.

(h) Each grant recipient shall report to the board on the progress of the initiative at least once during the grant period, and within two months of the end of the grant period shall submit a final report to the board that includes the outcome results.

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 25. Minnesota Statutes 2014, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) meets the asset limits in paragraph (d); and

(3) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a ~~$65~~ $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay ~~five~~ one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

Sec. 26. Minnesota Statutes 2014, section 256B.0916, subdivision 2, is amended to read:

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based waiver services for persons with developmental disabilities to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880; and

(2) statewide priorities identified in section 256B.092, subdivision 12.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

(f) The commissioner shall manage waiver allocations in such a manner as to fully use available state and federal waiver appropriations.

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

Sec. 27. Minnesota Statutes 2014, section 256B.0916, subdivision 11, is amended to read:

Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending in excess of the allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct their overspending for the ~~year~~ two years following the period when the overspending occurred. ~~Failure to correct overspending shall result in recoupment of spending in excess of the allocation~~ The commissioner shall recoup spending in excess of the allocation only in cases where statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

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

Sec. 28. Minnesota Statutes 2014, section 256B.0916, is amended by adding a subdivision to read:

Subd. 12. **Use of waiver allocations.** County and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services. If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county's or tribe's

available allocation and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

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

Sec. 29. Minnesota Statutes 2014, section 256B.097, subdivision 3, is amended to read:

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, 2014, statutory and rule changes related to the findings under clause (3) that promote

individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system by July 1, 2015.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph ~~(b)~~ (c), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision ~~2~~ 4, paragraph ~~(c)~~ (d), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under paragraph ~~(c)~~ (d) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision ~~2~~ (4), paragraph ~~(c)~~ (d).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Sec. 30. Minnesota Statutes 2014, section 256B.097, subdivision 4, is amended to read:

Subd. 4. **Regional quality councils.** (a) By July 1, 2015, the commissioner shall establish~~, as selected by the State Quality Council,~~ or continue the operation of three regional quality councils of key stakeholders, ~~including~~ as selected by the State Quality Council. One regional quality council shall be established in the Twin Cities metropolitan area, one shall be established in greater Minnesota, and one shall be the Quality Assurance Commission established under section 256B.0951. By July 1, 2016, the commissioner shall establish three additional regional quality councils, as selected by the State Quality Council. The regional quality councils established under this paragraph shall include regional representatives of:

(1) disability service recipients and their family members;

(2) disability service providers;

(3) disability advocacy groups; and

(4) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(b) In establishing the regional quality councils, the commissioner shall:

(1) appoint the members from the groups identified in paragraph (a) by July 1, 2015;

(2) designate a chair for each council or prescribe a process for each council to select a chair from among its members;

(3) set term limits for members of the regional quality councils;

(4) set the total number or maximum number of members of each regional council;

(5) set the number or proportion of members representing each of the groups identified in paragraph (a);

(6) set deadlines and requirements for annual reports to the chair of the State Quality Council and to the chairs of the legislative committees in the senate and house of representatives with primary jurisdiction over human services on the status, outcomes, improvement priorities, and activities in the regions; and

(7) convene a first meeting of each regional quality council by July 1, 2016, or identify a person responsible for convening the first meeting of each regional quality council and require that the person convene the first meeting by July 1, 2016.

~~(b)~~ (c) Each regional quality council shall:

(1) direct and monitor the community-based, person-directed quality assurance system in this section;

(2) approve a training program for quality assurance team members under clause (13);

(3) review summary reports from quality assurance team reviews and make recommendations to the State Quality Council regarding program licensure;

(4) make recommendations to the State Quality Council regarding the system;

(5) resolve complaints between the quality assurance teams, counties, providers, persons receiving services, their families, and legal representatives;

(6) analyze and review quality outcomes and critical incident data reporting incidents of life safety concerns immediately to the Department of Human Services licensing division;

(7) provide information and training programs for persons with disabilities and their families and legal representatives on service options and quality expectations;

(8) disseminate information and resources developed to other regional quality councils;

(9) respond to state-level priorities;

(10) establish regional priorities for quality improvement;

(11) submit an annual report to the State Quality Council on the status, outcomes, improvement priorities, and activities in the region;

(12) choose a representative to participate on the State Quality Council and assume other responsibilities consistent with the priorities of the State Quality Council; and

(13) recruit, train, and assign duties to members of quality assurance teams, taking into account the size of the service provider, the number of services to be reviewed, the skills necessary for the team members to complete the process, and ensure that no team member has a financial, personal, or family relationship with the facility, program, or service being reviewed or with anyone served at the facility, program, or service. Quality assurance teams must be comprised of county staff, persons receiving services or the person's families, legal representatives, members of advocacy organizations, providers, and other involved community members. Team members must complete the training program approved by the regional quality council and must demonstrate performance-based competency. Team members may be paid a per diem and reimbursed for expenses related to their participation in the quality assurance process.

~~(c)~~ (d) The commissioner shall monitor the safety standards, rights, and procedural protections for the monitoring of psychotropic medications and those identified under sections 245.825; 245.91 to 245.97; 245A.09, subdivision 2, paragraph (c), clauses (2) and (5); 245A.12; 245A.13; 252.41, subdivision 9; 256B.092, subdivision 1b, clause (7); 626.556; and 626.557.

~~(d)~~ (e) The regional quality councils may hire staff to perform the duties assigned in this subdivision.

~~(e)~~ (f) The regional quality councils may charge fees for their services.

~~(f)~~ (g) The quality assurance process undertaken by a regional quality council consists of an evaluation by a quality assurance team of the facility, program, or service. The

process must include an evaluation of a random sample of persons served. The sample must be representative of each service provided. The sample size must be at least five percent but not less than two persons served. All persons must be given the opportunity to be included in the quality assurance process in addition to those chosen for the random sample.

~~(g)~~ (h) A facility, program, or service may contest a licensing decision of the regional quality council as permitted under chapter 245A.

Sec. 31. Minnesota Statutes 2014, section 256B.49, subdivision 26, is amended to read:

Subd. 26. **Excess allocations.** (a) Effective through June 30, 2018, county and tribal agencies will be responsible for authorizations in excess of the annual allocation made by the commissioner. In the event a county or tribal agency authorizes in excess of the allocation made by the commissioner for a given allocation period, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct their overspending for the ~~year~~ two years following the period when the overspending occurred. ~~Failure to correct overauthorizations shall result in recoupment of authorizations in excess of the allocation.~~ The commissioner shall recoup funds spent in excess of the allocation only in cases where statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose. If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county's or tribe's available allocation and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

(b) Effective July 1, 2018, county and tribal agencies will be responsible for spending in excess of the annual allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The plan must state the actions the agency will take to correct its overspending for the two years following the period when the overspending occurred. The commissioner shall recoup funds spent in excess of the allocation only in cases when statewide spending exceeds the appropriation designated for the home and community-based services waivers. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and

community-based options to eligible waiver recipients within the resources allocated to it for that purpose. If a county or tribe does not submit a plan when required or implement the changes required, the commissioner shall assure access to waiver services within the county's or tribe's available allocation and take other actions needed to assure that all waiver participants in that county or tribe are receiving appropriate waiver services to meet their needs.

Sec. 32. Minnesota Statutes 2014, section 256B.49, is amended by adding a subdivision to read:

Subd. 27. **Use of waiver allocations.** (a) Effective until June 30, 2018, county and tribal agencies are responsible for authorizing the annual allocation made by the commissioner. In the event a county or tribal agency authorizes less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

(b) Effective July 1, 2018, county and tribal agencies are responsible for spending the annual allocation made by the commissioner. In the event a county or tribal agency spends less than 97 percent of the allocation, while maintaining a list of persons waiting for waiver services, the county or tribal agency must submit a corrective action plan to the commissioner for approval. The commissioner may determine a plan is unnecessary given the size of the allocation and capacity for new enrollment. The plan must state the actions the agency will take to assure reasonable and timely access to home and community-based waiver services for persons waiting for services.

Sec. 33. Minnesota Statutes 2014, section 256B.4913, subdivision 4a, is amended to read:

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

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

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

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

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

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

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

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

(3) ~~1.0~~ 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

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

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

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

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

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

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

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

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

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

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

Sec. 34. Minnesota Statutes 2014, section 256B.4913, subdivision 5, is amended to read:

Subd. 5. **Stakeholder consultation and county training.** (a) The commissioner shall continue consultation on regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, to assist in the full implementation of the new rate payment system and to make pertinent information available to the public through the department's Web site.

(b) The commissioner shall offer training at least annually for county personnel responsible for administering the rate-setting framework in a manner consistent with this section and section 256B.4914.

(c) The commissioner shall maintain an online instruction manual explaining the rate-setting framework. The manual shall be consistent with this section and section 256B.4914, and shall be accessible to all stakeholders including recipients, representatives of recipients, county or tribal agencies, and license holders.

(d) The commissioner shall not defer to the county or tribal agency on matters of technical application of the rate-setting framework, and a county or tribal agency shall not set rates in a manner that conflicts with this section or section 256B.4914.

Sec. 35. Minnesota Statutes 2014, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) for day services under subdivision 7:

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2014, section 256B.4914, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d) The commissioner shall establish a Monitoring Technology Review Panel to annually review and approve the plans, safeguards, and rates that include residential direct care provided remotely through monitoring technology. Lead agencies shall submit individual service plans that include supervision using monitoring technology to the Monitoring Technology Review Panel for approval. Individual service plans that include supervision using monitoring technology as of December 31, 2013, shall be submitted to the Monitoring Technology Review Panel, but the plans are not subject to approval.~~

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

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

Sec. 37. Minnesota Statutes 2014, section 256B.4914, subdivision 8, is amended to read:

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

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

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

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

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

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

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

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

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

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

(10) this is the subtotal rate;

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

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

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

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

Sec. 38. Minnesota Statutes 2014, section 256B.4914, subdivision 10, is amended to read:

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

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

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

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

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

(c) Using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014.

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

(1) values for transportation rates for day services;

(2) values for transportation rates in residential services;

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

(4) values for indirect services;

(5) values for nursing;

(6) component values for independent living skills;

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

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

(9) remote monitoring technology for nonresidential services;

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

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

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

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

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

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

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

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

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

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

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

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

(g) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

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

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

(2) service utilization;

(3) county and tribal allocation changes; and

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

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

(i) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a methodology sufficient to determine the shared staffing

levels necessary to meet, at a minimum, health and welfare needs of individuals who will be living together in shared residential settings, and the required shared staffing activities described in subdivision 2, paragraph (1). This determination methodology must ensure staffing levels are adaptable to meet the needs and desired outcomes for current and prospective residents in shared residential settings.

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

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

Sec. 39. Minnesota Statutes 2014, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the ~~state~~ commissioner.

(c) An application for a rate exception may be submitted for the following criteria:

(1) an individual has service needs that cannot be met through additional units of service; ~~or~~

(2) an individual's rate determined under subdivisions 6, 7, 8, and 9 ~~results~~ is so insufficient that it has resulted in an individual ~~being discharged~~ receiving a notice of discharge from the individual's provider; or

(3) an individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6, 7, 8, and 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation; and

(4) ~~the duration of the rate exception; and~~

~~(5)~~ any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient, interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the ~~individual's~~ request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient, the interested party, and the license holder in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

(j) The starting date for the rate exception will be the later of the date of the recipient's change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the number of exception requests received and the numbers granted, denied,

withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

(l) No later than January 15, 2016, the commissioner shall provide research findings on the estimated fiscal impact, the primary cost drivers, and common population characteristics of recipients with needs that cannot be met by the framework rates.

(m) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a process to determine eligibility for rate exceptions for individuals with rates determined under the methodology in section 256B.4913, subdivision 4a. Determination of the eligibility for an exception will occur as annual service renewals are completed.

(n) Approved rate exceptions will be implemented at such time that the individual's rate is no longer banded and remain in effect in all cases until an individual's needs change as defined in paragraph (c).

Sec. 40. Minnesota Statutes 2014, section 256B.4914, subdivision 15, is amended to read:

Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability waiver rates management system on January 1, 2014, the commissioner shall establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) Beginning January 1, 2014, the commissioner shall make annual adjustments to lead agencies' home and community-based waivered service budget allocations to adjust for rate differences and the resulting impact on county allocations upon implementation of the disability waiver rates system.

(c) ~~During the first two years of implementation under section 256B.4913,~~ Lead agencies exceeding their allocations shall be subject to the provisions under sections 256B.092 and 256B.49 ~~shall only be held liable for spending in excess of their allocations after a reallocation of resources by the commissioner under paragraph (b). The commissioner shall reallocate resources under sections 256B.092, subdivision 12, and 256B.49, subdivision 11a. The commissioner shall notify lead agencies of this process by July 1, 2014~~.

Sec. 41. **[256B.4915] DISABILITY WAIVER REIMBURSEMENT RATE ADJUSTMENTS.**

Subdivision 1. **Historical rate.** The commissioner of human services shall adjust the historical rates calculated in section 256B.4913, subdivision 4a, paragraph (b), in

effect during the banding period under section 256B.4913, subdivision 4a, paragraph (a), for each reimbursement rate increase effective on or after July 1, 2015.

Subd. 2. **Residential support services.** The commissioner of human services shall adjust the rates calculated in section 256B.4914, subdivision 6, paragraphs (b) and (c), for each reimbursement rate increase effective on or after July 1, 2015.

Subd. 3. **Day programs.** The commissioner of human services shall adjust the rates calculated in section 256B.4914, subdivision 7, for each reimbursement rate increase effective on or after July 1, 2015.

Subd. 4. **Unit-based services with programming.** The commissioner of human services shall adjust the rate calculated in section 256B.4914, subdivision 8, for each reimbursement rate increase effective on or after July 1, 2015.

Subd. 5. **Unit-based services without programming.** The commissioner of human services shall adjust the rate calculated in section 256B.4914, subdivision 9, for each reimbursement rate increase effective on or after July 1, 2015.

Sec. 42. Minnesota Statutes 2014, section 256B.492, is amended to read:

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

(a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

(1) ~~an individual's own home or family~~ home and community-based settings that comply with all requirements identified by the federal Centers for Medicare and Medicaid Services in the Code of Federal Regulations, title 42, section 441.301(c), and with the requirements of the federally approved transition plan and waiver plans for each home and community-based services waiver; and

(2) ~~a licensed adult foster care or child foster care setting of up to five people or community residential setting of up to five people; and~~ settings required by the Housing Opportunities for Persons with AIDS Program.

~~(3) community living settings as defined in section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units, and who receive services under a home and community-based waiver occupy no more than the greater of four or 25 percent of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Persons with AIDS Program.~~

(b) The settings in paragraph (a) must not~~:~~

~~(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;~~

~~(2) be located in a building on the grounds of or adjacent to a public or private institution;~~

~~(3) be a housing complex designed expressly around an individual's diagnosis or disability, unless required by the Housing Opportunities for Persons with AIDS Program;~~

~~(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and~~

~~(5)~~ have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

~~(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of July 1, 2012, and the setting does not meet the criteria of this section.~~

~~(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).~~

~~(e) Notwithstanding paragraphs (a) and (b), a program in Hennepin County, located in the city of Golden Valley, within the city of Golden Valley's Highway 55 West redevelopment area, that is not a provider-owned or controlled home and community-based setting, and is scheduled to open by July 1, 2016, is exempt from the restrictions in paragraphs (a) and (b). If the program fails to comply with the Centers for Medicare and Medicaid Services rules for home and community-based settings, the exemption is void.~~

~~(f) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.~~

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 43. Minnesota Statutes 2014, section 256B.5012, is amended by adding a subdivision to read:

Subd. 17. **ICF/DD rate increase effective July 1, 2016.** (a) For the rate period from July 1, 2016, to June 30, 2017, the commissioner shall increase operating payments for each facility reimbursed under this section equal to five percent of the operating payment rates in effect on June 30, 2016.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total

payment rate, including the variable rate but excluding the property-related payment rate in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

(c) Facilities that receive a rate increase under this subdivision shall use 90 percent of the additional revenue to increase compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustment in paragraph (a), except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and

(2) persons paid by the facility under a management contract.

(d) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (h).

(e) For public employees under a collective bargaining agreement, the increases for wages and benefits for certain staff are available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. A provider that receives additional revenue for compensation-related cost increases under paragraph (c), that is a public employer, and whose fiscal year ends on June 30 of each year, must use the portion of the rate increase specified in paragraph (c) only for compensation-related cost increases implemented between July 1, 2016, and August 1, 2016. A provider that receives additional revenue for compensation-related cost increases under paragraph (c), that is a public employer, and whose fiscal year ends on December 31 of each year, must use the portion of the compensation-related cost increases specified in paragraph (c) only for compensation-related cost increases implemented during the contract period.

(f) For a facility that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under paragraph (h), in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the facility shall be deemed to have met all the requirements of this subdivision in regard to the members

of the bargaining unit. Upon request, the facility shall produce the letter of acceptance for the commissioner.

(g) The commissioner shall amend state grant contracts that include direct personnel-related grant expenditures to include the allocation for the portion of the contract related to employee compensation. Grant contracts for compensation-related services must be amended to pass through the adjustment within 60 days of the effective date of the increase and must be retroactive to the effective date of the rate adjustment.

(h) A facility that receives a rate adjustment under paragraph (a) that is subject to paragraphs (c) and (d) shall prepare and, upon request, submit to the commissioner a distribution plan that specifies the amount of money the facility expects to receive that is subject to the requirements of paragraphs (c) and (d), including how that money will be distributed to increase compensation for employees.

(i) Within six months of the effective date of the rate adjustment, the facility shall post the distribution plan required under paragraph (h) for a period of at least six weeks in an area of the facility's operation to which all eligible employees have access and shall provide instructions for employees who do not believe they have received the wage and other compensation-related increases specified in the distribution plan. The instructions must include a mailing address, e-mail address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative.

Sec. 44. **[256Q.01] PLAN ESTABLISHED.**

A savings plan known as the Minnesota ABLE plan is established. In establishing this plan, the legislature seeks to encourage and assist individuals and families in saving private funds for the purpose of supporting individuals with disabilities to maintain health, independence, and quality of life, and to provide secure funding for disability-related expenses on behalf of designated beneficiaries with disabilities that will supplement, but not supplant, benefits provided through private insurance, the Medicaid program under title XIX of the Social Security Act, the Supplemental Security Income program under title XVI of the Social Security Act, the beneficiary's employment, and other sources.

Sec. 45. **[256Q.02] CITATION.**

This chapter may be cited as the "Minnesota Achieving a Better Life Experience Act" or "Minnesota ABLE Act."

Sec. 46. **[256Q.03] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of this chapter, the terms defined in this section have the meanings given them.

Subd. 2. **ABLE account.** "ABLE account" has the meaning given in section 529A(e)(6) of the Internal Revenue Code.

Subd. 3. **ABLE account plan or plan.** "ABLE account plan" or "plan" means the qualified ABLE program, as defined in section 529A(b) of the Internal Revenue Code, provided for in this chapter.

Subd. 4. **Account.** "Account" means the formal record of transactions relating to an ABLE plan beneficiary.

Subd. 5. **Account owner.** "Account owner" means the designated beneficiary of the account.

Subd. 6. **Annual contribution limit.** "Annual contribution limit" has the meaning given in section 529A(b)(2) of the Internal Revenue Code.

Subd. 7. **Application.** "Application" means the form executed by a prospective account owner to enter into a participation agreement and open an account in the plan. The application incorporates by reference the participation agreement.

Subd. 8. **Board.** "Board" mans the State Board of Investment.

Subd. 9. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 10. **Contribution.** "Contribution" means a payment directly allocated to an account for the benefit of a beneficiary.

Subd. 11. **Department.** "Department" means the Department of Human Services.

Subd. 12. **Designated beneficiary or beneficiary.** "Designated beneficiary" or "beneficiary" has the meaning given in section 529A(e)(3) of the Internal Revenue Code and further defined through regulations issued under that section.

Subd. 13. **Earnings.** "Earnings" means the total account balance minus the investment in the account.

Subd. 14. **Eligible individual.** "Eligible individual" has the meaning given in section 529A(e)(1) of the Internal Revenue Code and further defined through regulations issued under that section.

Subd. 15. **Executive director.** "Executive director" means the executive director of the State Board of Investment.

Subd. 16. **Internal Revenue Code.** "Internal Revenue Code" means the Internal Revenue Code of 1986, as amended.

Subd. 17. **Investment in the account.** "Investment in the account" means the sum of all contributions made to an account by a particular date minus the aggregate amount

of contributions included in distributions or rollover distributions, if any, made from the account as of that date.

Subd. 18. **Member of the family.** "Member of the family" has the meaning given in section 529A(e)(4) of the Internal Revenue Code.

Subd. 19. **Participation agreement.** "Participation agreement" means an agreement to participate in the Minnesota ABLE plan between an account owner and the state through its agencies, the commissioner, and the board.

Subd. 20. **Person.** "Person" means an individual, trust, estate, partnership, association, company, corporation, or the state.

Subd. 21. **Plan administrator.** "Plan administrator" means the person selected by the commissioner and the board to administer the daily operations of the ABLE account plan and provide record keeping, investment management, and other services for the plan.

Subd. 22. **Qualified disability expense.** "Qualified disability expense" has the meaning given in section 529A(e)(5) of the Internal Revenue Code and further defined through regulations issued under that section.

Subd. 23. **Qualified distribution.** "Qualified distribution" means a withdrawal from an ABLE account to pay the qualified disability expenses of the beneficiary of the account. A qualified withdrawal may be made by the beneficiary, by an agent of the beneficiary who has the power of attorney, or by the beneficiary's legal guardian.

Subd. 24. **Rollover distribution.** "Rollover distribution" means a transfer of funds made:

(1) from one account in another state's qualified ABLE program to an account for the benefit of the same designated beneficiary or an eligible individual who is a family member of the former designated beneficiary; or

(2) from one account to another account for the benefit of an eligible individual who is a family member of the former designated beneficiary.

Subd. 25. **Total account balance.** "Total account balance" means the amount in an account on a particular date or the fair market value of an account on a particular date.

Sec. 47. **[256Q.04] ABLE PLAN REQUIREMENTS.**

Subdivision 1. **State residency requirement.** The designated beneficiary of an ABLE account must be a resident of Minnesota, or the resident of a state that has entered into a contract with Minnesota to provide its residents access to the Minnesota ABLE plan.

Subd. 2. **Single account requirement.** No more than one ABLE account shall be established per beneficiary, except as permitted under section 529A(c)(4) of the Internal Revenue Code.

Subd. 3. **Accounts-type plan.** The plan must be operated as an accounts-type plan. A separate account must be maintained for each designated beneficiary for whom contributions are made.

Subd. 4. **Contribution and account requirements.** Contributions to an ABLE account are subject to the requirements of section 529A(b)(2) of the Internal Revenue Code prohibiting noncash contributions and contributions in excess of the annual contribution limit. The total account balance may not exceed the maximum account balance limit imposed under section 136G.09, subdivision 8.

Subd. 5. **Limited investment direction.** Designated beneficiaries may not direct the investment of assets in their accounts more than twice in any calendar year.

Subd. 6. **Security for loans.** An interest in an account must not be used as security for a loan.

Sec. 48. **[256Q.05] ABLE PLAN ADMINISTRATION.**

Subdivision 1. **Plan to comply with federal law.** The commissioner shall ensure that the plan meets the requirements for an ABLE account under section 529A of the Internal Revenue Code, including any regulations released after the effective date of this section. The commissioner may request a private letter ruling or rulings from the Internal Revenue Service or secretary of health and human services and must take any necessary steps to ensure that the plan qualifies under relevant provisions of federal law.

Subd. 2. **Plan rules and procedures.** (a) The commissioner shall establish the rules, terms, and conditions for the plan, subject to the requirements of this chapter and section 529A of the Internal Revenue Code.

(b) The commissioner shall prescribe the application forms, procedures, and other requirements that apply to the plan.

Subd. 3. **Consultation with other state agencies; annual fee.** In designing and establishing the plan's requirements and in negotiating or entering into contracts with third parties under subdivision 4, the commissioner shall consult with the executive director of the board and the commissioner of the Office of Higher Education. The commissioner and the executive director shall establish an annual fee, equal to a percentage of the average daily net assets of the plan, to be imposed on account owners to recover the costs of administration, record keeping, and investment management as provided in subdivision 5.

Subd. 4. **Administration.** The commissioner shall administer the plan, including accepting and processing applications, verifying state residency, verifying eligibility, maintaining account records, making payments, and undertaking any other necessary tasks to administer the plan. Notwithstanding other requirements of this chapter, the

commissioner shall adopt rules for purposes of implementing and administering the plan. The commissioner may contract with one or more third parties to carry out some or all of these administrative duties, including providing incentives. The commissioner and the board may jointly contract with third-party providers if the commissioner and board determine that it is desirable to contract with the same entity or entities for administration and investment management.

Subd. 5. **Authority to impose fees.** The commissioner, or the commissioner's designee, may impose annual fees, as provided in subdivision 3, on account owners to recover the costs of administration. The commissioner must keep the fees as low as possible, consistent with efficient administration, so that the returns on savings invested in the plan are as high as possible.

Subd. 6. **Federally mandated reporting.** (a) As required under section 529A(d) of the Internal Revenue Code, the commissioner or the commissioner's designee shall submit a notice to the secretary of the treasury upon the establishment of each ABLE account. The notice must contain the name and state of residence of the designated beneficiary and other information as the secretary may require.

(b) As required under section 529A(d) of the Internal Revenue Code, the commissioner or the commissioner's designee shall submit electronically on a monthly basis to the commissioner of Social Security, in a manner specified by the commissioner of Social Security, statements on relevant distributions and account balances from all ABLE accounts.

Subd. 7. **Data.** (a) Data on ABLE accounts and designated beneficiaries of ABLE accounts are private data on individuals or nonpublic data as defined in section 13.02.

(b) The commissioner may share or disseminate data classified as private or nonpublic in this subdivision as follows:

(1) with other state or federal agencies, only to the extent necessary to verify the identity of, determine the eligibility of, or process applications for an eligible individual participating in the Minnesota ABLE plan; and

(2) with a nongovernmental person, only to the extent necessary to carry out the functions of the Minnesota ABLE plan, provided the commissioner has entered into a data-sharing agreement with the person, as provided in section 13.05, subdivision 6, prior to sharing data under this clause or a contract with that person that complies with section 13.05, subdivision 11, as applicable.

Sec. 49. **[256Q.06] PLAN ACCOUNTS.**

Subdivision 1. **Contributions to an account.** Any person may make contributions to an ABLE account on behalf of a designated beneficiary. Contributions to an account made by persons other than the account owner become the property of the account owner. A person does not acquire an interest in an ABLE account by making contributions to an account. Contributions to an account must be made in cash, by check, or by other commercially acceptable means, as permitted by the Internal Revenue Service and approved by the plan administrator in cooperation with the commissioner and the board.

Subd. 2. **Contribution and account limitations.** Contributions to an ABLE account are subject to the requirements of section 529A(b) of the Internal Revenue Code. The total account balance of an ABLE account may not exceed the maximum account balance limit imposed under section 136G.09, subdivision 8. The plan administrator must reject any portion of a contribution to an account that exceeds the annual contribution limit or that would cause the total account balance to exceed the maximum account balance limit imposed under section 136G.09, subdivision 8.

Subd. 3. **Authority of account owner.** An account owner is the only person entitled to:

(1) request distributions;

(2) request rollover distributions; or

(3) change the beneficiary of an ABLE account to a member of the family of the current beneficiary, but only if the beneficiary to whom the ABLE account is transferred is an eligible individual.

Subd. 4. **Effect of plan changes on participation agreement.** Amendments to this chapter automatically amend the participation agreement. Any amendments to the operating procedures and policies of the plan automatically amend the participation agreement after adoption by the commissioner or the board.

Subd. 5. **Special account to hold plan assets in trust.** All assets of the plan, including contributions to accounts, are held in trust for the exclusive benefit of account owners. Assets must be held in a separate account in the state treasury to be known as the Minnesota ABLE plan account or in accounts with the third-party provider selected pursuant to section 256Q.05, subdivision 4. Plan assets are not subject to claims by creditors of the state, are not part of the general fund, and are not subject to appropriation by the state. Payments from the Minnesota ABLE plan account shall be made under this chapter.

Sec. 50. **[256Q.07] INVESTMENT OF ABLE ACCOUNTS.**

Subdivision 1. **State Board of Investment to invest.** The State Board of Investment shall invest the money deposited in accounts in the plan.

Subd. 2. **Permitted investments.** The board may invest the accounts in any permitted investment under section 11A.24, except that the accounts may be invested without limit in investment options from open-ended investment companies registered under the federal Investment Company Act of 1940, United States Code, title 15, sections 80a-1 to 80a-64.

Subd. 3. **Contracting authority.** The board may contract with one or more third parties for investment management, record keeping, or other services in connection with investing the accounts. The board and commissioner may jointly contract with third-party providers if the commissioner and board determine that it is desirable to contract with the same entity or entities for administration and investment management.

Sec. 51. **[256Q.08] ACCOUNT DISTRIBUTIONS.**

Subdivision 1. **Qualified distribution methods.** (a) Qualified distributions may be made:

(1) directly to participating providers of goods and services that are qualified disability expenses, if purchased for a beneficiary;

(2) in the form of a check payable to both the beneficiary and provider of goods or services that are qualified disability expenses; or

(3) directly to the beneficiary, if the beneficiary has already paid qualified disability expenses.

(b) Qualified distributions must be withdrawn proportionally from contributions and earnings in an account owner's account on the date of distribution as provided in section 529A of the Internal Revenue Code.

Subd. 2. **Distributions upon death of beneficiary.** Upon the death of a beneficiary, the amount remaining in the beneficiary's account must be distributed pursuant to section 529A(f) of the Internal Revenue Code.

Subd. 3. **Nonqualified distribution.** An account owner may request a nonqualified distribution from an account at any time. Nonqualified distributions are based on the total account balances in an account owner's account and must be withdrawn proportionally from contributions and earnings as provided in section 529A of the Internal Revenue Code. The earnings portion of a nonqualified distribution is subject to a federal additional tax pursuant to section 529A of the Internal Revenue Code. For purposes of this subdivision, "earnings portion" means the ratio of the earnings in the account to the total account balance, immediately prior to the distribution, multiplied by the distribution.

Sec. 52. Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72, is amended to read:

Sec. 47. **COMMISSIONER TO SEEK AMENDMENT FOR EXCEPTION TO CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY.**

~~By July 1, 2014, if necessary,~~ The commissioner shall ~~request an amendment to the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to~~ establish an exception to the consumer-directed community supports budget methodology for the home and community-based services waivers under Minnesota Statutes, sections 256B.092 and 256B.49, to provide up to 20 percent more funds for ~~those~~:

(1) consumer-directed community supports participants who have ~~their 21st birthday and graduate~~ graduated from high school ~~between 2013 to 2015~~ and are authorized ~~for~~ to receive more services under consumer-directed community supports prior to graduation than the amount they are eligible to receive under the current consumer-directed community supports budget methodology; and

(2) those who are currently using licensed services for employment supports or services during the day which cost more annually than the person would spend under a consumer-directed community supports plan for individualized employment supports or services during the day. The exception is limited to those who can demonstrate either that they will have to leave consumer-directed community supports and use other waiver services because their need for day or employment supports cannot be met within the consumer-directed community supports budget limits or they will move to consumer-directed community supports and their services will cost less than services currently being used. ~~The commissioner shall consult with the stakeholder group authorized under Minnesota Statutes, section 256B.0657, subdivision 11, to implement this provision.~~ The exception process shall be effective ~~upon federal approval~~ for persons eligible through June 30, ~~2017~~ 2019.

Sec. 53. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY 1, 2016.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by five percent for the rate period from July 1, 2016, to June 30, 2017, for services rendered on or after those dates. County or tribal contracts for services specified in this section must be amended to pass through the rate increase within 60 days of the effective date of the increase.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities, including consumer-directed community supports, under Minnesota Statutes, section 256B.092;

(2) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) home care nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) community first services and supports under Minnesota Statutes, section 256B.85;

(10) essential community supports under Minnesota Statutes, section 256B.0922;

(11) day training and habilitation services for adults with developmental disabilities under Minnesota Statutes, sections 252.41 to 252.46, including the additional cost to counties of the rate adjustments on day training and habilitation services provided as a social service;

(12) alternative care services under Minnesota Statutes, section 256B.0913;

(13) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(14) semi-independent living services (SILS) under Minnesota Statutes, section 252.275;

(15) consumer support grants under Minnesota Statutes, section 256.476;

(16) family support grants under Minnesota Statutes, section 252.32;

(17) housing access grants under Minnesota Statutes, section 256B.0658;

(18) self-advocacy grants under Laws 2009, chapter 101;

(19) technology grants under Laws 2009, chapter 79;

(20) aging grants under Minnesota Statutes, sections 256.975 to 256.977 and 256B.0917;

(21) deaf and hard-of-hearing grants, including community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2;

(22) deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233, 256C.25, and 256C.261;

(23) Disability Linkage Line grants under Minnesota Statutes, section 256.01, subdivision 24;

(24) transition initiative grants under Minnesota Statutes, section 256.478;

(25) employment support grants under Minnesota Statutes, section 256B.021, subdivision 6; and

(26) grants provided to people who are eligible for the Housing Opportunities for Persons with AIDS program under Minnesota Statutes, section 256B.492.

(c) A managed care plan or county-based purchasing plan receiving state payments for the services, grants, and programs in paragraph (b) must include the increase in their payments to providers. For the purposes of this subdivision, entities that provide care coordination are providers. To implement the rate increase in paragraph (a), capitation rates paid by the commissioner to managed care plans and county-based purchasing plans under Minnesota Statutes, section 256B.69, shall reflect a five percent increase for the services, grants, and programs specified in paragraph (b) for the period beginning July 1, 2016.

(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective date in paragraph (a).

(e) Providers that receive a rate increase under paragraph (a) shall use 90 percent of the additional revenue to increase compensation-related costs for employees directly employed by the program on or after the effective date of the rate adjustment in paragraph (a), except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider; and

(2) persons paid by the provider under a management contract.

(f) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (k).

(g) For public employees under a collective bargaining agreement, the increases for wages and benefits are available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. A provider that receives additional revenue for compensation-related cost increases under paragraph (e), that is a public employer, and whose fiscal year ends on June 30 of each year, must use the portion of the rate increase specified in paragraph (e) only for compensation-related cost increases implemented between July 1, 2016, and August 1, 2016. A provider that receives additional revenue for compensation-related cost increases under paragraph (e), that is a public employer, and whose fiscal year ends on December 31 of each year, must use the portion of the compensation-related cost increases specified in paragraph (e) only for compensation-related cost increases implemented during the contract period.

(h) For a provider that has employees who are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under paragraph (k), in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the provider shall be deemed to have met all the requirements of this section in regard to the members of the bargaining unit. Upon request, the provider shall produce the letter of acceptance for the commissioner.

(i) The commissioner shall amend state grant contracts that include direct personnel-related grant expenditures to include the allocation for the portion of the contract related to employee compensation. Grant contracts for compensation-related services must be amended to pass through these adjustments within 60 days of the effective date of the increase under paragraph (a) and must be retroactive to the effective date of the rate adjustment.

(j) The Board on Aging and its area agencies on aging shall amend their grants that include direct personnel-related grant expenditures to include the rate adjustment for the portion of the grant related to employee compensation. Grants for compensation-related services must be amended to pass through these adjustments within 60 days of the effective date of the increase under paragraph (a) and must be retroactive to the effective date of the rate adjustment.

(k) A provider that receives a rate adjustment under paragraph (a) that is subject to paragraph (e) shall prepare and, upon request, submit to the commissioner a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of paragraph (e), including how that money will be distributed to increase compensation for employees.

(l) Within six months of the effective date of the rate adjustment, the provider shall post the distribution plan required under paragraph (k) for a period of at least six weeks in an area of the provider's operation to which all eligible employees have access and shall provide instructions for employees who do not believe they have received the wage and other compensation-related increases specified in the distribution plan. The instructions must include a mailing address, e-mail address, and telephone number that the employee may use to contact the commissioner or the commissioner's representative.

Sec. 54. **DIRECTION TO COMMISSIONER; PEDIATRIC HOME CARE STUDY.**

The commissioner of human services shall review the status of delayed discharges of pediatric patients and determine if an increase in the medical assistance payment rate for intensive pediatric home care would reduce the number of delayed discharges of pediatric patients. The commissioner shall report the results of the review to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over health and human services policy and finance by January 15, 2016.

Sec. 55. **DIRECTION TO COMMISSIONER; REPORTS REQUIRED.**

The commissioner of human services shall develop and submit reports to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over health and human services policy and finance on the implementation of Minnesota Statutes, sections 256B.0916, subdivisions 2, 11, and 12, and 256B.49, subdivisions 26 and 27. The commissioner shall submit two reports, one by February 15, 2018, and the second by February 15, 2019.

Sec. 56. **DIRECTION TO COMMISSIONER; DAY TRAINING AND HABILITATION.**

For service agreements renewed or entered into on or after January 1, 2016, the commissioner of human services shall calculate the transportation portion of the payment for day training and habilitation programs using payments factors found in Minnesota Statutes, section 256B.4914, subdivision 7, clauses (16) and (17).

Sec. 57. **HOME AND COMMUNITY-BASED SERVICES INCENTIVE POOL.**

The commissioner of human services shall develop an initiative to provide incentives for innovation in achieving integrated competitive employment, living in the most integrated setting, and other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes. The initial requests for proposals must be issued by October 1, 2015.

ARTICLE 5

NURSING FACILITY PAYMENT REFORM AND WORKFORCE DEVELOPMENT

Section 1. **[144.1503] HOME AND COMMUNITY-BASED SERVICES EMPLOYEE SCHOLARSHIP PROGRAM.**

Subdivision 1. **Creation.** The home and community-based services employee scholarship grant program is established for the purpose of assisting qualified provider applicants to fund employee scholarships for education in nursing and other health care fields.

Subd. 2. **Provision of grants.** The commissioner shall make grants available to qualified providers of older adult services. Grants must be used by home and community-based service providers to recruit and train staff through the establishment of an employee scholarship fund.

Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to individuals who are 65 years of age and older in home and community-based settings, including housing with services establishments as defined in section 144D.01, subdivision 4; adult day care as defined in section 245A.02, subdivision 2a; and home care services as defined in section 144A.43, subdivision 3.

(b) Qualifying providers must establish a home and community-based services employee scholarship program, as specified in subdivision 4. Providers that receive funding under this section must use the funds to award scholarships to employees who work an average of at least 16 hours per week for the provider.

Subd. 4. **Home and community-based services employee scholarship program.** Each qualifying provider under this section must propose a home and community-based services employee scholarship program. Providers must establish criteria by which funds are to be distributed among employees. At a minimum, the scholarship program must cover employee costs related to a course of study that is expected to lead to career

advancement with the provider or in the field of long-term care, including home care, care of persons with disabilities, or nursing.

Subd. 5. **Participating providers.** The commissioner shall publish a request for proposals in the State Register, specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. **Application requirements.** Eligible providers seeking a grant shall submit an application to the commissioner. Applications must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the organization to enhance the education of its workforce, the process for determining which employees will be eligible for scholarships, any other sources of funding for scholarships, the expected degrees or credentials eligible for scholarships, the amount of funding sought for the scholarship program, a proposed budget detailing how funds will be spent, and plans for retaining eligible employees after completion of their scholarship.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award for grants and make grant selections based on the information provided in the grant application, including the demonstrated need for an applicant provider to enhance the education of its workforce, the proposed employee scholarship selection process, the applicant's proposed budget, and other criteria as determined by the commissioner. Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires.

Subd. 8. **Reporting requirements.** Participating providers shall submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner. The report shall include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the name of the recipient, the current position of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, and the expected or actual program completion date. During the grant period, the commissioner may require and collect from grant recipients other information necessary to evaluate the program.

Sec. 2. Minnesota Statutes 2014, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical

plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility

must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site

of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the

allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(x) to license and certify ~~a total~~ to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement ~~project~~ projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County ~~that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes.~~ and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating ~~cost~~ payment rates for the new nursing ~~facility~~ facilities shall be determined based on the interim and settle-up payment provisions of section 256B.431, 256B.434, or 256B.441 or Minnesota Rules, ~~part 9549.0057, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;~~ parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256B.431, 256B.434, or 256B.441. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256B.441, subdivision 60;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital

corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds

for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256B.437;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.441; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Sec. 3. Minnesota Statutes 2014, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4e, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(6) except for individuals described in clause (7), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(7) for individuals assigned a case mix classification A as described under section 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in

the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256B.0915, subdivision 3a, ~~paragraph~~ paragraphs (a) and (e). This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (6) for case mix classification A; and

(8) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 4. Minnesota Statutes 2014, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) ~~The monthly limit for the cost of waivered services to an individual elderly waiver client except for individuals described in paragraphs (b) and (d) shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented.~~ Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the ~~rate~~ monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment.

(b) The monthly limit for the cost of waivered services under paragraph (a) to an individual elderly waiver client assigned to a case mix classification A ~~under paragraph (a)~~ with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in ~~paragraph~~ paragraphs (a) and (e).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a) ~~or~~,

(b), (d), or (e), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a) ~~or~~, (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in ~~paragraph~~ paragraphs (a) and (e).

(e) Effective July 1, 2016, and each July 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous June 30 shall be adjusted by the greater of the difference between any legislatively adopted home and community-based provider rate increase effective on July 1 and the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431, 256B.434, and 256B.441, effective the previous January 1.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 5. Minnesota Statutes 2014, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not

exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a)~~, until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented~~. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(h) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be adjusted by the greater of the difference between any legislatively adopted home and community-based provider rate increase effective on July 1 and the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431, 256B.434, and 256B.441, effective the previous January 1.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 6. Minnesota Statutes 2014, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050

to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. ~~Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.~~

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) Twenty-four-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(j) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits for 24-hour customized living services under this subdivision shall be adjusted by the greater of the difference between any legislatively adopted home and community-based provider rate increase effective on July 1 and the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431, 256B.434, and 256B.441, effective the previous January 1.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 7. Minnesota Statutes 2014, section 256B.431, subdivision 2b, is amended to read:

Subd. 2b. **Operating costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

(b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.

(c) The commissioner shall analyze and evaluate each nursing facility's cost report of allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, and size of the nursing facility. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing facilities in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing facilities established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. For rate years beginning on or after July 1, 1989, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1, 1989, may choose to have the commissioner apply either the care related limits or the other operating cost limits calculated for facilities located in geographic group II, or both, if either of the limits calculated for the group II facilities is higher. The efficiency incentive for geographic group I nursing facilities must be calculated based on geographic group I limits. The phase-in must be established utilizing the chosen limits. For purposes of these exceptions to the geographic grouping requirements, the definitions in Minnesota Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing facility payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing facility is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to

an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

(1) allow nursing facilities that have an average length of stay of 180 days or less in their skilled nursing level of care, 125 percent of the care related limit and 105 percent of the other operating cost limit established by rule; and

(2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other operating cost limit established by rule.

For the purpose of calculating the other operating cost efficiency incentive for nursing facilities referred to in clause (1) or (2), the commissioner shall use the other operating cost limit established by rule before application of the 105 percent.

(e) The commissioner shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.

(f) Each nursing facility shall receive an operating cost payment rate equal to the sum of the nursing facility's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing facility's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing facility's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle up. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability or payments in lieu of real estate tax of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property

for those purposes. For rate years beginning on or after July 1, 1987, the reported actual real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be adjusted to include an amount equal to one-half of the dollar change in real estate taxes from the prior year. The commissioner shall include a reported actual special assessment, and reported actual license fees required by the Minnesota Department of Health, for each nursing facility as an operating cost of that nursing facility. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing facility's reported Public Employee Retirement Act contribution for the reporting year as apportioned to the care-related operating cost categories and other operating cost categories multiplied by the appropriate composite index or indices established pursuant to paragraph (e) as costs under this paragraph. Total adjusted real estate tax liability, payments in lieu of real estate tax, actual special assessments paid, the indexed Public Employee Retirement Act contribution, and license fees paid as required by the Minnesota Department of Health, for each nursing facility (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the care-related operating cost limits or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

~~(h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility's allowable historical raw food cost per diem and 115 percent of the median historical allowable raw food cost per diem of the corresponding geographic group.~~

~~The rate adjustment shall be reduced by the applicable phase-in percentage as provided under subdivision 2h.~~

Sec. 8. Minnesota Statutes 2014, section 256B.431, subdivision 36, is amended to read:

Subd. 36. **Employee scholarship costs and training in English as a second language.** (a) For the period between July 1, 2001, and June 30, 2003, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section, a scholarship per diem of 25 cents to the total operating payment rate. For the two rate years beginning on or after October 1, 2015, through September 30, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least ~~20~~ ten hours per week at the facility except the administrator, ~~department supervisors, and registered nurses~~ and to reimburse student loan expenses for newly hired and recently graduated registered nurses and licensed practical nurses, and training expenses for nursing assistants as defined in section 144A.61, subdivision 2, who are newly hired and have graduated within the last 12 months; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) ~~A facility receiving~~ All facilities may annually request a rate adjustment under this subdivision ~~may submit~~ by submitting information to the commissioner on a schedule ~~determined by the commissioner~~ and ~~on~~ in a form supplied by the commissioner ~~a calculation of the scholarship per diem, including: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the per diem amount of these costs based on actual resident days~~. The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.

(c) ~~On July 1, 2003, the commissioner shall remove the 25 cent scholarship per diem from the total operating payment rate of each facility.~~

~~(d) For rate years beginning after June 30, 2003, the commissioner shall provide to each facility the scholarship per diem determined in paragraph (b).~~ In calculating the per diem under paragraph (b), the commissioner shall allow ~~only~~ costs related to tuition ~~and~~, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.

(d) The rate increase under this subdivision is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this subdivision.

(e) Nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.

Sec. 9. Minnesota Statutes 2014, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** ~~(a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.~~

~~(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.~~

~~(c)~~ A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, ~~and October~~ January 1, 2016, and January 1, 2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

~~(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the~~

~~form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:~~

~~(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;~~

~~(2) adoption of new technology to improve quality or efficiency;~~

~~(3) improved quality as measured in the Nursing Home Report Card;~~

~~(4) reduced acute care costs; and~~

~~(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.~~

~~(c) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:~~

~~(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;~~

~~(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and~~

~~(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (c), and subdivision 16.~~

~~The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a~~

~~form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.~~

Sec. 10. Minnesota Statutes 2014, section 256B.434, is amended by adding a subdivision to read:

Subd. 4i. **Construction project rate adjustments for certain nursing facilities.** (a) This subdivision applies to nursing facilities with at least 120 active beds as of January 1, 2015, that have projects approved in 2015 under the nursing facility moratorium exception process in section 144A.073. When each facility's moratorium exception construction project is completed, the facility must receive the rate adjustment allowed under subdivision 4f. In addition to that rate adjustment, facilities with at least 120 active beds, but not more than 149 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $4; and facilities with at least 150 active beds, but not more than 160 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $12.50.

(b) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2015 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increases allowed in this subdivision.

Sec. 11. Minnesota Statutes 2014, section 256B.441, subdivision 1, is amended to read:

Subdivision 1. **~~Rebasing~~ Calculation of nursing facility operating payment rates.** (a) The commissioner shall ~~rebase nursing facility operating payment rates to align payments to facilities with the cost of providing care. The rebased~~ calculate operating payment rates ~~shall be calculated~~ using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(b) The ~~new~~ operating payment rates based on this section shall take effect ~~beginning~~ with the rate year beginning ~~October 1, 2008, and shall be phased in over eight rate years through October 1, 2015. For each year of the phase-in, the operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year~~ January 1, 2016.

~~(c) Operating payment rates shall be rebased on October 1, 2016, and every two years after that date.~~

~~(d)~~ (c) Each cost reporting year shall begin on October 1 and end on the following September 30. ~~Beginning in 2014,~~ A statistical and cost report shall be filed by each nursing facility by February 1 in a form and manner specified by the commissioner. Notice of rates shall be distributed by ~~August~~ November 15 and the rates shall go into effect on ~~October~~ January 1 for one year.

~~(e) Effective October 1, 2014, property rates shall be rebased in accordance with section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under section 256B.434. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.~~

Sec. 12. Minnesota Statutes 2014, section 256B.441, subdivision 5, is amended to read:

Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 11, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Sec. 13. Minnesota Statutes 2014, section 256B.441, subdivision 6, is amended to read:

Subd. 6. **Allowed costs.** (a) "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by the department for accuracy; reasonableness, in accordance with the requirements set forth in title XVIII of the federal Social Security Act and the interpretations in the provider reimbursement manual; and compliance with this section

and generally accepted accounting principles. All references to costs in this section shall be assumed to refer to allowed costs.

(b) For facilities where employees are represented by collective bargaining agents, costs related to the salaries and wages, payroll taxes, and employer's share of fringe benefit costs, except employer health insurance costs, for facility employees who are members of the bargaining unit are allowed costs only if:

(1) these costs are incurred pursuant to a collective bargaining agreement. The commissioner shall allow until March 1 following the date on which the cost report was required to be submitted for a collective bargaining agent to notify the commissioner if a collective bargaining agreement, effective on the last day of the cost reporting year, was in effect; or

(2) the collective bargaining agent notifies the commissioner by October 1 following the date on which the cost report was required to be submitted that these costs are incurred pursuant to an agreement or understanding between the facility and the collective bargaining agent.

(c) In any year when a portion of a facility's reported costs are not allowed costs under paragraph (b), when calculating the operating payment rate for the facility, the commissioner shall use the facility's allowed costs from the facility's second most recent cost report in place of the nonallowed costs. For the purpose of setting the price for other operating costs under subdivision 51, the price shall be reduced by the difference between the nonallowed costs and the allowed costs from the facility's second most recent cost report.

Sec. 14. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 11a. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage and reinsurance, actual expenses incurred for self-insured plans, and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for employees who meet the definition of full-time employees and their families under the federal Affordable Care Act, Public Law 111-148, and part-time employees.

Sec. 15. Minnesota Statutes 2014, section 256B.441, subdivision 13, is amended to read:

Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; ~~until September 30, 2013, long-term care consultation fees under~~

~~section 256B.0911, subdivision 6;~~ family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section 256B.437; ~~or~~ single bed room incentives under section 256B.431, subdivision 42; property taxes ~~and property insurance~~, assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under subdivision 46c; performance-based incentive payments under subdivision 46d; special dietary needs under subdivision 51b; and PERA.

Sec. 16. Minnesota Statutes 2014, section 256B.441, subdivision 14, is amended to read:

Subd. 14. **Facility average case mix index.** "Facility average case mix index" or "CMI" means a numerical ~~value~~ score that describes the relative resource use for all residents within the groups under the resource utilization group ~~(RUG-III)~~ (RUG) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by total days for all residents in the facility. The RUG's weights used ~~in this section shall be as follows for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1 1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1 0.651; and DDF 1.000~~ shall be based on the system prescribed in section 256B.438.

Sec. 17. Minnesota Statutes 2014, section 256B.441, subdivision 17, is amended to read:

Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, ~~health,~~ dental, workers' compensation, and other employee insurances and pension, except for the Public Employees Retirement Association and employer health insurance costs; profit sharing~~,~~; and retirement plans for which the employer pays all or a portion of the costs.

Sec. 18. Minnesota Statutes 2014, section 256B.441, subdivision 30, is amended to read:

Subd. 30. **~~Peer groups~~ Median total care-related cost per diem and other operating per diem determined.** ~~Facilities shall be classified into three groups by county. The groups shall consist of:~~

~~(1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;~~

~~(2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and~~

~~(3) group three: facilities in all other counties~~ (a) The commissioner shall determine the median total care-related per diem to be used in subdivision 50 and the median other operating per diem to be used in subdivision 51 using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

(b) The median total care-related per diem shall be equal to the median direct care cost for a RUG's weight of 1.00 for facilities located in the counties listed in paragraph (a).

(c) The median other operating per diem shall be equal to the median other operating per diem for facilities located in the counties listed in paragraph (a). The other operating per diem shall be the sum of each facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by each facility's resident days.

Sec. 19. Minnesota Statutes 2014, section 256B.441, subdivision 31, is amended to read:

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on ~~September 30, 2008~~ December 31, 2015, under Minnesota Rules and Minnesota Statutes~~, not including planned closure rate adjustments under section 256B.437 or single bed room incentives under section 256B.431, subdivision 42~~.

Sec. 20. Minnesota Statutes 2014, section 256B.441, subdivision 33, is amended to read:

Subd. 33. **Rate year.** "Rate year" means the 12-month period beginning on ~~October~~ January 1 following the second most recent reporting year.

Sec. 21. Minnesota Statutes 2014, section 256B.441, subdivision 35, is amended to read:

Subd. 35. **Reporting period.** "Reporting period" means the one-year period beginning on October 1 and ending on the following September 30 during which incurred costs are accumulated and then reported on the statistical and cost report. If a facility is reporting for an interim or settle-up period, the reporting period beginning date may be a date other than October 1. An interim or settle-up report must cover at least five months, but no more than 17 months, and must always end on September 30.

Sec. 22. Minnesota Statutes 2014, section 256B.441, subdivision 40, is amended to read:

Subd. 40. **Standardized days.** "Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category. When a facility has resident days at a penalty classification, these days shall be reported as resident days at the RUG class established immediately after the penalty period, if available, and otherwise, at the RUG class in effect before the penalty began.

Sec. 23. Minnesota Statutes 2014, section 256B.441, subdivision 44, is amended to read:

Subd. 44. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts, and using data as provided in the Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with ~~a maximum~~ the number of points ~~available and number of points~~ assigned as determined by the commissioner using the methodology established according to this subdivision. ~~The scores determined for all quality measures shall be totaled.~~ The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) ~~For the initial rate year under the new payment system, the quality measures shall include:~~

~~(1) staff turnover;~~

~~(2) staff retention;~~

~~(3) use of pool staff;~~

~~(4) quality indicators from the minimum data set; and~~

~~(5) survey deficiencies.~~

~~(d)~~ Beginning ~~July 1, 2013~~ January 1, 2016, the quality score shall ~~be a value between zero and 100, using data as provided in the Minnesota nursing home report card, with~~ include up to 50 ~~percent derived from~~ points related to the Minnesota quality indicators score, up to 40 ~~percent derived from~~ points related to the resident quality of life score, and up to ten ~~percent derived from~~ points related to the state inspection results score.

~~(e)~~ (d) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph ~~(d)~~ (c), or the methodology for computing the total quality score, effective July 1 of any year beginning in ~~2014~~ 2017, with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Sec. 24. Minnesota Statutes 2014, section 256B.441, subdivision 46c, is amended to read:

Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.** The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments shall be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d). For the period from October 1, 2015, to December 31, 2016, rate adjustments provided under this subdivision shall be effective for 15 months. Beginning ~~October 1, 2015~~ January 1, 2017, annual rate adjustments provided under this subdivision shall be effective for one year, starting ~~October~~ January 1 and ending the following ~~September 30~~ December 31. The increase in this subdivision shall be included in the external fixed payment rate under subdivisions 13 and 53.

Sec. 25. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 46d. **Performance-based incentive payments.** The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit proposals and select those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this subdivision to operate the incentive payments within funds appropriated for this purpose. The commissioner shall approve proposals through a memorandum of understanding which shall specify various levels of payment for various levels of performance. Incentive payments to facilities under this subdivision shall be in the form of time-limited rate adjustments which shall be included in the external fixed payment rate under subdivisions 13 and 53. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Minnesota Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 26. Minnesota Statutes 2014, section 256B.441, subdivision 48, is amended to read:

Subd. 48. **Calculation of ~~operating~~ care-related per diems.** The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care-related per diem shall be the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. ~~The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days.~~

Sec. 27. Minnesota Statutes 2014, section 256B.441, subdivision 50, is amended to read:

Subd. 50. **Determination of total care-related limit.** (a) The ~~limit on the~~ median total care-related per diem shall be determined ~~for each peer group and facility type group combination. A facility's total care-related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility-specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per diem reduced to the limit. If a reduction of the total care-related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem~~ according to subdivision 30.

(b) ~~Beginning with rates determined for October 1, 2016, the~~ A facility's total care-related limit shall be a variable amount based on each facility's quality score, as determined under subdivision 44, in accordance with clauses (1) to ~~(4)~~ (3):

(1) ~~for each facility, the commissioner shall determine the quality score, subtract 40, divide by 40, and convert to a percentage~~ the quality score shall be multiplied by 0.5625;

(2) ~~if the value determined in clause (1) is less than zero, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group~~ add 89.375 to the amount determined in clause (1), and divide the total by 100; and

(3) ~~if the value determined in clause (1) is greater than 100 percent, the total care-related limit shall be 125 percent of the median for the facility's peer and facility type group; and~~ multiply the amount determined in clause (2) by the median total care-related per diem determined in subdivision 30, paragraph (b).

~~(4) if the value determined in clause (1) is greater than zero and less than 100 percent, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group plus one-fifth of the percentage determined in clause (1).~~

(c) A RUG's weight of 1.00 shall be used in the calculation of the median total care-related per diem, and in comparisons of facility-specific direct care costs to the median.

(d) A facility that is above its total care-related limit as determined according to paragraph (b) shall have its total care-related per diem reduced to its limit. If a reduction of the total care-related per diem is necessary due to this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

Sec. 28. Minnesota Statutes 2014, section 256B.441, subdivision 51, is amended to read:

Subd. 51. **Determination of other operating ~~limit~~ price.** ~~The limit on the~~ A price for other operating ~~per diem~~ costs shall be determined ~~for each peer group~~. ~~A facility's other operating per diem shall be limited to~~ The price shall be calculated as 105 percent of the median ~~for its peer group~~ other operating per diem described in subdivision 30, paragraph (c). ~~A facility that is above that limit shall have its other operating per diem reduced to the limit.~~

Sec. 29. Minnesota Statutes 2014, section 256B.441, subdivision 51a, is amended to read:

Subd. 51a. **Exception ~~allowing contracting~~ for specialized care facilities.** (a) For rate years beginning on or after ~~October~~ January 1, 2016, ~~the commissioner may negotiate increases to the care-related limit for nursing facilities that provide specialized care, at a cost to the general fund not to exceed $600,000 per year. The commissioner shall publish a request for proposals annually, and may negotiate increases to the limits that shall apply for either one or two years before the increase shall be subject to a new proposal and negotiation.~~ the care-related limit ~~may~~ for specialized care facilities shall be increased by ~~up to~~ 50 percent.

(b) ~~In selecting facilities with which to negotiate, the commissioner shall consider:~~ "Specialized care facilities" are defined as a facility having a program licensed under chapter 245A and Minnesota Rules, chapter 9570, or a facility with 96 beds on January 1, 2015, located in Robbinsdale that specializes in the treatment of Huntington's Disease.

~~(1) the diagnoses or other circumstances of residents in the specialized program that require care that costs substantially more than the RUG's rates associated with those residents;~~

~~(2) the nature of the specialized program or programs offered to meet the needs of these individuals; and~~

~~(3) outcomes achieved by the specialized program.~~

Sec. 30. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 51b. **Special dietary needs.** The commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility's most recently reported allowable raw food cost per diem and 115 percent of the median allowable raw food cost per diem. For rate years beginning on or after January 1, 2016, this amount shall be removed from allowable raw food per diem costs under operating costs and included in the external fixed per diem rate under subdivisions 13 and 53.

Sec. 31. Minnesota Statutes 2014, section 256B.441, subdivision 53, is amended to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(d) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

~~(d) Until September 30, 2013, the portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.~~

~~(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.~~

~~(f)~~ (e) The portion related to planned closure rate adjustments shall be as determined under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436. ~~Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016.~~

~~Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.~~

(f) The single bed room incentives shall be as determined under section 256B.431, subdivision 42.

(g) The portions related to ~~property insurance,~~ real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to employer health insurance costs shall be the allowable costs divided by resident days.

(i) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

~~(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.~~

(j) The portion related to quality improvement incentive payment rate adjustments shall be as determined under subdivision 46c.

(k) The portion related to performance-based incentive payments shall be as determined under subdivision 46d.

(l) The portion related to special dietary needs shall be the per diem amount determined under subdivision 51b.

~~(j)~~ (m) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to ~~(i)~~ (l).

Sec. 32. Minnesota Statutes 2014, section 256B.441, subdivision 54, is amended to read:

Subd. 54. **Determination of total payment rates.** ~~In rate years when rates are rebased,~~ The total care-related per diem, other operating price, and external fixed per diem for each facility shall be converted to payment rates. The total payment rate for a RUG's weight of 1.00 shall be the sum of the total care-related payment rate, other operating payment rate, ~~efficiency incentive,~~ external fixed cost rate, and the property rate determined under section 256B.434. To determine a total payment rate for each RUG's level, the total care-related payment rate shall be divided into the direct care payment rate

and the other care-related payment rate, and the direct care payment rate multiplied by the RUG's weight for each RUG's level ~~using the weights in subdivision 14~~.

Sec. 33. Minnesota Statutes 2014, section 256B.441, subdivision 55a, is amended to read:

Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between October 1, 2011, and the day before ~~the phase-in under subdivision 55 is complete~~ operating payment rates are determined under this section, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other RUGs shall be computed as provided under subdivision 54.

(b) For operating payment rates implemented beginning the day when the ~~phase-in under subdivision 55 is complete~~ operating payment rates are determined under this section, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate with a weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGs shall be computed under subdivision 54. The rate increase allowed in this paragraph shall take effect only upon federal approval.

(c) Rates determined under this subdivision shall take effect beginning October 1, 2011, based on cost reports for the reporting year ending September 30, 2010, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

(d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by August 31, 2011, or by June 30 of any subsequent year.

(e) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under paragraph (a) or (b), and the rates that

the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 ~~or 55~~ as determined by the commissioner.

(f) The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Sec. 34. Minnesota Statutes 2014, section 256B.441, subdivision 56, is amended to read:

Subd. 56. **Hold harmless.** (a) For the rate years beginning ~~October 1, 2008, to October~~ on or after January 1, 2016, no nursing facility shall receive an operating cost payment rate less than its prior system operating cost payment rate ~~under section 256B.434. For rate years beginning between October 1, 2009, and October 1, 2015, no nursing facility shall receive an operating payment rate less than its operating payment rate in effect on September 30, 2009~~. The comparison of operating payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

(b) For rate years beginning on or after January 1, 2016, no facility shall be subject to a care-related payment rate limit reduction greater than five percent of the median determined in subdivision 30.

Sec. 35. Minnesota Statutes 2014, section 256B.441, subdivision 63, is amended to read:

Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. Beginning in fiscal year 2015, to the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with subdivision 54 and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256B.431, subdivision 2r, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health will consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) ~~notwithstanding subdivision 58, beginning October 1, 2014,~~ the quality-based rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility shall be for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This subdivision is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this subdivision from January 1, 2016, to December 31, 2017.

Sec. 36. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 65. **Nursing facility in Golden Valley.** Effective for the rate year beginning January 1, 2016, and all subsequent rate years, the operating payment rate for a facility located in the city of Golden Valley at 3915 Golden Valley Road with 44 licensed rehabilitation beds as of January 7, 2015, must be calculated without the application of subdivisions 50 and 51.

Sec. 37. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 66. **Nursing facilities in border cities.** Effective for the rate year beginning January 1, 2016, and annually thereafter, operating payment rates of a nonprofit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the city of Breckenridge, and is reimbursed under this section, section 256B.431, or section 256B.434, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the commissioner, for the equivalent RUG's weight of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The Minnesota facility's operating payment rate with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. If the adjustments under this subdivision result in a rate that exceeds the limits in subdivisions 50 and 51 in a given rate year, the facility's rate shall not be subject to those limits for that rate year. This subdivision shall apply only if it results in a rate increase.

Sec. 38. Minnesota Statutes 2014, section 256B.50, subdivision 1, is amended to read:

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter or allowed costs under section 256B.441 and reimbursement rules of the commissioner if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors as provided by section 256B.433, subdivision 3. Appeals must be filed in accordance with procedures in this section. This section does not apply to a request from a resident or long-term care facility for reconsideration of the classification of a resident under section 144.0722.

EFFECTIVE DATE. This section is effective July 1, 2015, and applies to appeals filed on or after that date.

Sec. 39. Minnesota Statutes 2014, section 256I.05, subdivision 2, is amended to read:

Subd. 2. **Monthly rates; exemptions.** This subdivision applies to a residence that on August 1, 1984, was licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0690. Notwithstanding the provisions of subdivision 1c, the rate paid to a facility reimbursed under this subdivision shall be determined under section 256B.431, ~~or under section~~ 256B.434, or 256B.441, if the facility is accepted by the commissioner

for participation in the alternative payment demonstration project. The rate paid to this facility shall also include adjustments to the group residential housing rate according to subdivision 1, and any adjustments applicable to supplemental service rates statewide.

Sec. 40. **DIRECTION TO COMMISSIONER; NURSING FACILITY PAYMENT REFORM REPORT.**

By January 1, 2017, the commissioner of human services shall evaluate and report to the house of representatives and senate committees and divisions with jurisdiction over nursing facility payment rates on:

(1) the impact of using cost report data to set rates without accounting for cost report to rate year inflation;

(2) the impact of the quality adjusted care limits;

(3) the ability of nursing facilities to attract and retain employees, including how rate increases are being passed through to employees, under the new payment system;

(4) the efficacy of the critical access nursing facility program under Minnesota Statutes, section 256B.441, subdivision 63, given the new nursing facility payment system;

(5) creating a process for the commissioner to designate certain facilities as specialized care facilities for difficult-to-serve populations; and

(6) limiting the hold harmless in Minnesota Statutes, section 256B.441, subdivision 56.

Sec. 41. **PROPERTY RATE SETTING.**

The commissioner shall conduct a study, in consultation with stakeholders and experts, of property rate setting, based on a rental value approach for Minnesota nursing facilities, and shall report the findings to the house of representatives and senate committees and divisions with jurisdiction over nursing facility payment rates by March 1, 2016, for a system implementation date of January 1, 2017. The commissioner shall:

(1) contract with at least two firms to conduct appraisals of all nursing facilities in the medical assistance program. Each firm shall conduct appraisals of approximately equal portions of all nursing facilities assigned to them at random. The appraisals shall determine the value of the land, building, and equipment of each nursing facility, taking into account the quality of construction and current condition of the building;

(2) use the information from the appraisals to complete the design of a fair rental value system and calculate a replacement value and an effective age for each nursing facility. Nursing facilities may request an appraisal by a second firm which shall be assigned randomly by the commissioner. The commissioner shall use the findings of

the second appraisal. If the second firm increases the appraisal value by more than five percent, the state shall pay for the second appraisal. Otherwise, the nursing facility shall pay the cost of the appraisal. Results of appraisals are not otherwise subject to appeal under section 256B.50; and

(3) include in the report required under this section the following items:

(i) a description of the proposed rental value system;

(ii) options for adjusting the system parameters that vary the cost of implementing the new property rate system and an analysis of individual nursing facilities under the current property payment rate and the rates under various approaches to calculating rates under the rental value system;

(iii) recommended steps for transition to the rental value system;

(iv) an analysis of the expected long-term incentives of the rental value system for nursing facilities to maintain and replace buildings, including how the current exceptions to the moratorium process under Minnesota Statutes, section 144A.073, may be adapted; and

(v) bill language for implementation of the rental value system.

Sec. 42. **REVISOR'S INSTRUCTION.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research, and Fiscal Analysis, Department of Human Services, and stakeholders, shall prepare legislation for the 2016 legislative session to recodify laws governing nursing home payments and rates in Minnesota Statutes, chapter 256B, and in Minnesota Rules, chapter 9549.

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

Sec. 43. **REPEALER.**

Minnesota Statutes 2014, sections 256B.434, subdivision 19b; and 256B.441, subdivisions 14a, 19, 50a, 52, 55, 58, and 62, are repealed.

ARTICLE 6

PUBLIC HEALTH AND HEALTH CARE DELIVERY

Section 1. **[62A.67] SHORT TITLE.**

Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

EFFECTIVE DATE. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 2. **[62A.671] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the terms defined in this section have the meanings given.

Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.

Subd. 3. **Health care provider.** "Health care provider" has the meaning provided in section 62A.63, subdivision 2.

Subd. 4. **Heath carrier.** "Health carrier" has the meaning provided in section 62A.011, subdivision 2.

Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred and are designed to pay benefits directly to the policyholder.

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or a vendor of medical care as defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Subd. 7. **Originating site.** "Originating site" means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.

Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means the transmission of a patient's medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.

Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmissions does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or

support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

EFFECTIVE DATE. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 3. **[62A.672] COVERAGE OF TELEMEDICINE SERVICES.**

Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.

(b) Nothing in this section shall be construed to:

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

Subd. 2. **Parity between telemedicine and in-person services.** A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine commensurate with the cost of delivering health care services through telemedicine. The distant site provider is responsible for reimbursing any fees to the originating site.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.

EFFECTIVE DATE. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2014, section 103I.205, subdivision 4, is amended to read:

Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e), section 103I.401, subdivision 2, or section 103I.601, subdivision 2, a person may not drill, construct, repair, or seal a well or boring unless the person has a well contractor's license in possession.

(b) A person may construct, repair, and seal a monitoring well if the person:

(1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches of civil or geological engineering;

(2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

(3) is a professional geoscientist licensed under sections 326.02 to 326.15;

(4) is a geologist certified by the American Institute of Professional Geologists; or

(5) meets the qualifications established by the commissioner in rule.

A person must register with the commissioner as a monitoring well contractor on forms provided by the commissioner.

(c) A person may do the following work with a limited well/boring contractor's license in possession. A separate license is required for each of the six activities:

(1) installing or repairing well screens or pitless units or pitless adaptors and well casings from the pitless adaptor or pitless unit to the upper termination of the well casing;

(2) constructing, repairing, and sealing drive point wells or dug wells;

(3) installing well pumps or pumping equipment;

(4) sealing wells;

(5) constructing, repairing, or sealing dewatering wells; or

(6) constructing, repairing, or sealing bored geothermal heat exchangers.

(d) A person may construct, repair, and seal an elevator boring with an elevator boring contractor's license.

(e) Notwithstanding other provisions of this chapter requiring a license or registration, a license or registration is not required for a person who complies with the other provisions of this chapter if the person is:

(1) an individual who constructs a well on land that is owned or leased by the individual and is used by the individual for farming or agricultural purposes or as the individual's place of abode;

(2) an individual who performs labor or services for a contractor licensed or registered under the provisions of this chapter in connection with the construction, sealing, or repair of a well or boring at the direction and under the personal supervision of a contractor licensed or registered under the provisions of this chapter; or

(3) a licensed plumber who is repairing submersible pumps or water pipes associated with well water systems if:

(i) the repair location is within an area where there is no licensed or registered well contractor within ~~25~~ 50 miles; and

(ii) the licensed plumber complies with all of the requirements of this chapter and all relevant sections of the plumbing code.

Sec. 5. **[144.1506] PRIMARY CARE RESIDENCY EXPANSION GRANT PROGRAM.**

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(1) "eligible primary care residency program" means a program that meets the following criteria:

(i) is located in Minnesota;

(ii) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery; and

(iii) is accredited by the Accreditation Council for Graduate Medical Education or presents a credible plan to obtain accreditation;

(2) "eligible project" means a project to establish a new eligible primary care residency program or create at least one new residency slot in an existing eligible primary care residency program; and

(3) "new residency slot" means the creation of a new residency position and the execution of a contract with a new resident in a residency program.

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary care residency expansion grants to eligible primary care residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited primary care residency program;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits residency programs;

(3) establishing new residency programs or new resident training slots;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new family medicine resident training slots; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. **Applications for expansion grants.** Eligible primary care residency programs seeking a grant shall apply to the commissioner. Applications must include the number of new family medicine residency slots planned or under contract; attestation that funding will be used to support an increase in the number of available residency slots; a description of the training to be received by the new residents, including the location of training; a description of the project, including all costs associated with the project; all sources of funds for the project; detailed uses of all funds for the project; the results expected; and a plan to maintain the new residency slot after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of expansion grant applications.** The commissioner shall review each application to determine whether or not the residency program application is complete and whether the proposed new residency program and any new residency slots are eligible for a grant. The commissioner shall award grants to support up to six family medicine, general internal medicine, or general pediatrics residents; four psychiatry residents; two geriatrics residents; and two general surgery residents. If insufficient applications are received from any eligible specialty, funds may be redistributed to applications from other eligible specialties.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Appropriations made to the program do not cancel and are available until expended.

Sec. 6. Minnesota Statutes 2014, section 144.293, subdivision 5, is amended to read:

Subd. 5. **Exceptions to consent requirement.** (a) This section does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency;

(2) to other providers within related health care entities when necessary for the current treatment of the patient; or

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent.

(b) A provider may release a deceased patient's health care records to another provider for the purposes of diagnosing or treating the deceased patient's surviving adult child.

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

Sec. 7. **[144.586] REQUIREMENTS FOR CERTAIN NOTICES AND DISCHARGE PLANNING.**

Subdivision 1. **Observation stay notice.** (a) Each hospital, as defined under section 144.50, subdivision 2, shall provide oral and written notice to each patient that the hospital places in observation status of such placement not later than 24 hours after such placement. The oral and written notices must include:

(1) a statement that the patient is not admitted to the hospital but is under observation status;

(2) a statement that observation status may affect the patient's Medicare coverage for:

(i) hospital services, including medications and pharmaceutical supplies; or

(ii) home or community-based care or care at a skilled nursing facility upon the patient's discharge; and

(3) a recommendation that the patient contact the patient's health insurance provider or the Office of the Ombudsman for Long-Term Care or Office of the Ombudsman for State Managed Health Care Programs or the Beneficiary and Family Centered Care Quality Improvement Organization to better understand the implications of placement in observation status.

(b) The hospital shall document the date in the patient's record that the notice required in paragraph (a) was provided to the patient, the patient's designated representative such as the patient's health care agent, legal guardian, conservator, or another person acting as the patient's representative.

Subd. 2. **Postacute care discharge planning.** Each hospital, including hospitals designated as critical access hospitals, must comply with the federal hospital requirements for discharge planning which include:

(1) conducting a discharge planning evaluation that includes an evaluation of:

(i) the likelihood of the patient needing posthospital services and of the availability of those services; and

(ii) the patient's capacity for self-care or the possibility of the patient being cared for in the environment from which the patient entered the hospital;

(2) timely completion of the discharge planning evaluation under clause (1) by hospital personnel so that appropriate arrangements for posthospital care are made before discharge, and to avoid unnecessary delays in discharge;

(3) including the discharge planning evaluation under clause (1) in the patient's medical record for use in establishing an appropriate discharge plan. The hospital must discuss the results of the evaluation with the patient or individual acting on behalf of the patient. The hospital must reassess the patient's discharge plan if the hospital determines that there are factors that may affect continuing care needs or the appropriateness of the discharge plan; and

(4) providing counseling, as needed, for the patient and family members or interested persons to prepare them for posthospital care. The hospital must provide a list of available Medicare-eligible home care agencies or skilled nursing facilities that serve the patient's geographic area, or other area requested by the patient if such care or placement is indicated and appropriate. Once the patient has designated their preferred providers, the hospital will assist the patient in securing care covered by their health plan or within the care network. The hospital must not specify or otherwise limit the qualified providers that are available to the patient. The hospital must document in the patient's record that the list was presented to the patient or to the individual acting on the patient's behalf.

Sec. 8. **[144.999] LIFE-SAVING ALLERGY MEDICATION.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Administer" means the direct application of an epinephrine auto-injector to the body of an individual.

(c) "Authorized entity" means entities that fall in the categories of recreation camps, colleges and universities, preschools and day cares, and any other category of entities or organizations that the commissioner authorizes to obtain and administer epinephrine

auto-injectors pursuant to this section. This definition does not include a school covered under section 121A.2207.

(d) "Commissioner" means the commissioner of health.

(e) "Epinephrine auto-injector" means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

(f) "Provide" means to supply one or more epinephrine auto-injectors to an individual or the individual's parent, legal guardian, or caretaker.

Subd. 2. **Commissioner duties.** The commissioner may identify additional categories of entities or organizations to be authorized entities if the commissioner determines that individuals may come in contact with allergens capable of causing anaphylaxis. Beginning July 1, 2016, the commissioner may annually review the categories of authorized entities and may authorize additional categories of authorized entities as the commissioner deems appropriate. The commissioner may contract with a vendor to perform the review and identification of authorized entities.

Subd. 3. **Obtaining and storing epinephrine auto-injectors.** (a) Notwithstanding section 151.37, an authorized entity may obtain and possess epinephrine auto-injectors to be provided or administered to an individual if, in good faith, an employee or agent of an authorized entity believes that the individual is experiencing anaphylaxis regardless of whether the individual has a prescription for an epinephrine auto-injector. The administration of an epinephrine auto-injector in accordance with this section is not the practice of medicine.

(b) An authorized entity may obtain epinephrine auto-injectors from pharmacies licensed as wholesale drug distributors pursuant to section 151.47. Prior to obtaining an epinephrine auto-injector, an owner, manager, or authorized agent of the entity must present to the pharmacy a valid certificate of training obtained pursuant to subdivision 5.

(c) An authorized entity shall store epinephrine auto-injectors in a location readily accessible in an emergency and in accordance with the epinephrine auto-injector's instructions for use and any additional requirements that may be established by the commissioner. An authorized entity shall designate employees or agents who have completed the training program required under subdivision 5 to be responsible for the storage, maintenance, and control of epinephrine auto-injectors obtained and possessed by the authorized entity.

Subd. 4. **Use of epinephrine auto-injectors.** (a) An owner, manager, employee, or agent of an authorized entity who has completed the training required under subdivision 5 may:

(1) provide an epinephrine auto-injector for immediate administration to an individual or the individual's parent, legal guardian, or caregiver if the employee or agent believes, in good faith, the individual is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy; or

(2) administer an epinephrine auto-injector to an individual who the employee or agent believes, in good faith, is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy.

(b) Nothing in this section shall be construed to require any authorized entity to maintain a stock of epinephrine auto-injectors.

Subd. 5. **Training.** (a) In order to use an epinephrine auto-injector as authorized under subdivision 4, an individual must complete, every two years, an anaphylaxis training program conducted by a nationally recognized organization experienced in training laypersons in emergency health treatment, a statewide organization with experience providing training on allergies and anaphylaxis under the supervision of board-certified allergy medical advisors, or an entity or individual approved by the commissioner to provide an anaphylaxis training program. The commissioner may approve specific entities or individuals to conduct the training program or may approve categories of entities or individuals to conduct the training program. Training may be conducted online or in person and, at a minimum, must cover:

(1) how to recognize signs and symptoms of severe allergic reactions, including anaphylaxis;

(2) standards and procedures for the storage and administration of an epinephrine auto-injector; and

(3) emergency follow-up procedures.

(b) The entity or individual conducting the training shall issue a certificate to each person who successfully completes the anaphylaxis training program. The commissioner may develop, approve, and disseminate a standard certificate of completion. The certificate of completion shall be valid for two years from the date issued.

Subd. 6. **Good samaritan protections.** Any act or omission taken pursuant to this section by an authorized entity that possesses and makes available epinephrine auto-injectors and its employees or agents, a pharmacy or manufacturer that dispenses epinephrine auto-injectors to an authorized entity, or an individual or entity that conducts the training described in subdivision 5 is considered "emergency care, advice, or assistance" under section 604A.01.

Sec. 9. Minnesota Statutes 2014, section 144A.75, subdivision 13, is amended to read:

Subd. 13. **Residential hospice facility.** (a) "Residential hospice facility" means a facility that resembles a single-family home located in a residential area that directly provides 24-hour residential and support services in a home-like setting for hospice patients as an integral part of the continuum of home care provided by a hospice and that houses:

(1) no more than eight hospice patients; or

(2) at least nine and no more than 12 hospice patients with the approval of the local governing authority, notwithstanding section 462.357, subdivision 8.

(b) Residential hospice facility also means a facility that directly provides 24-hour residential and support services for hospice patients and that:

(1) houses no more than 21 hospice patients;

(2) meets hospice certification regulations adopted pursuant to title XVIII of the federal Social Security Act, United States Code, title 42, section 1395, et seq.; and

(3) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a 40-bed non-Medicare certified nursing home as of January 1, 2015.

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

Sec. 10. Minnesota Statutes 2014, section 144E.001, is amended by adding a subdivision to read:

Subd. 5h. **Community medical response emergency medical technician.** "Community medical response emergency medical technician" or "CEMT" means a person who is certified as an emergency medical technician, who is a member of a registered medical response unit under this chapter, and who meets the requirements for additional certification as a CEMT as specified in section 144E.275, subdivision 7.

Sec. 11. Minnesota Statutes 2014, section 144E.275, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, the following definitions apply:

(a) "Medical response unit" means an organized service recognized by a local political subdivision whose primary responsibility is to respond to medical emergencies to provide initial medical care before the arrival of a licensed ambulance service. Medical response units may, subject to requirements specified elsewhere in this chapter and only when requested by the patient's primary physician, advanced practice registered nurse, physician assistant, or care team, provide, at the direction of a medical director, episodic population health support, episodic individual patient education, and prevention education programs.

(b) "Specialized medical response unit" means an organized service recognized by a board-approved authority other than a local political subdivision that responds to medical emergencies as needed or as required by local procedure or protocol.

Sec. 12. Minnesota Statutes 2014, section 144E.275, is amended by adding a subdivision to read:

Subd. 7. **Community medical response emergency medical technician.** (a) To be eligible for certification by the board as a CEMT, an individual shall:

(1) be currently certified as an EMT or AEMT;

(2) have two years of service as an EMT or AEMT;

(3) be a member of a registered medical response unit as defined in this chapter;

(4) successfully complete a CEMT training program from a college or university that has been approved by the board or accredited by a board-approved national accrediting organization. The training must include clinical experience under the supervision of the medical response unit medical director, an advanced practice registered nurse, a physician assistant, or a public health nurse operating under the direct authority of a local unit of government; and

(5) complete a board-approved application form.

(b) A CEMT must practice in accordance with protocols and supervisory standards established by the medical response unit medical director in accordance with section 144E.265.

(c) A CEMT may provide services as approved by the medical response unit medical director.

(d) A CEMT may provide episodic individual patient education and prevention education only as directed by a patient care plan developed by the patient's primary physician, an advanced practice registered nurse, or a physician assistant, in conjunction with the medical response unit medical director and relevant local health care providers. The care plan must ensure that the services provided by the CEMT are consistent with services offered by the patient's health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient.

(e) A CEMT is subject to all certification, disciplinary, complaint, and other regulatory requirements that apply to EMTs under this chapter.

(f) A CEMT may not provide services defined in section 144A.471, subdivisions 6 and 7, except a CEMT may provide verbal or visual reminders to the patient to:

(1) take a regularly scheduled medication, but not to provide or bring the patient medication; and

(2) follow regularly scheduled treatment or exercise plans.

Sec. 13. Minnesota Statutes 2014, section 145.4131, subdivision 1, is amended to read:

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

(10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form; ~~and~~

(11) the medical specialty of the physician performing the abortion;

(12) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:

(i) any medical actions taken to preserve the life of the born alive infant;

(ii) whether the born alive infant survived; and

(iii) the status of the born alive infant, should the infant survive, if known.

Sec. 14. Minnesota Statutes 2014, section 145.423, is amended to read:

145.423 ABORTION; LIVE BIRTHS.

Subdivision 1. **Recognition; medical care.** A ~~live child born~~ born alive infant as a result of an abortion shall be fully recognized as a human person, and accorded immediate protection under the law. All reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, shall be taken by the responsible medical personnel to preserve the life and health of the ~~child~~ born alive infant.

Subd. 2. **Physician required.** When an abortion is performed after the twentieth week of pregnancy, a physician, other than the physician performing the abortion, shall be immediately accessible to take all reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, to preserve the life and health of any ~~live birth~~ born alive infant that is the result of the abortion.

Subd. 3. **Death.** If a ~~child~~ born alive infant described in subdivision 1 dies after birth, the body shall be disposed of in accordance with the provisions of section 145.1621.

Subd. 4. **Definition of born alive infant.** (a) In determining the meaning of any Minnesota statute, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of Minnesota, the words "person," "human being," "child," and "individual" shall include every infant member of the species Homo sapiens who is born alive at any stage of development.

(b) As used in this section, the term "born alive," with respect to a member of the species Homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who, after such expulsion or extraction, breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of a natural or induced labor, cesarean section, or induced abortion.

(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species Homo sapiens at any point prior to being born alive, as defined in this section.

Subd. 5. **Civil and disciplinary actions.** (a) Any person upon whom an abortion has been performed, or the parent or guardian of the mother if the mother is a minor, and the abortion results in the infant having been born alive, may maintain an action for death of or injury to the born alive infant against the person who performed the abortion if the death or injury was a result of simple negligence, gross negligence, wantonness, willfulness, intentional conduct, or another violation of the legal standard of care.

(b) Any responsible medical personnel that does not take all reasonable measures consistent with good medical practice to preserve the life and health of the born alive infant, as required by subdivision 1, may be subject to the suspension or revocation of that person's professional license by the professional board with authority over that person. Any person who has performed an abortion and against whom judgment has been rendered pursuant to paragraph (a) shall be subject to an automatic suspension of the person's professional license for at least one year and said license shall be reinstated only after the person's professional board requires compliance with this section by all board licensees.

(c) Nothing in this subdivision shall be construed to hold the mother of the born alive infant criminally or civilly liable for the actions of a physician, nurse, or other licensed health care provider in violation of this section to which the mother did not give her consent.

Subd. 6. **Protection of privacy in court proceedings.** In every civil action brought under this section, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female

should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

Subd. 7. **Status of born alive infant.** Unless the abortion is performed to save the life of the woman or fetus, or, unless one or both of the parents of the born alive infant agree within 30 days of the birth to accept the parental rights and responsibilities for the child, the child shall be an abandoned ward of the state and the parents shall have no parental rights or obligations as if the parental rights had been terminated pursuant to section 260C.301. The child shall be provided for pursuant to chapter 256J.

Subd. 8. **Severability.** If any one or more provision, section, subdivision, sentence, clause, phrase, or word of this section or the application of it to any person or circumstance is found to be unconstitutional, it is declared to be severable and the balance of this section shall remain effective notwithstanding such unconstitutionality. The legislature intends that it would have passed this section, and each provision, section, subdivision, sentence, clause, phrase, or word, regardless of the fact that any one provision, section, subdivision, sentence, clause, phrase, or word is declared unconstitutional.

Subd. 9. **Short title.** This act may be cited as the "Born Alive Infants Protection Act."

Sec. 15. **[145.471] PRENATAL TRISOMY DIAGNOSIS AWARENESS ACT.**

Subdivision 1. **Short title.** This section shall be known and may be cited as the "Prenatal Trisomy Diagnosis Awareness Act."

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

(1) "commissioner" means the commissioner of health;

(2) "deliver" means providing information to an expectant parent and, if appropriate, other family members, in a written format;

(3) "health care practitioner" means a medical professional that provides prenatal or postnatal care and administers or requests administration of a diagnostic or screening test to a pregnant woman that detects for trisomy conditions; and

(4) "trisomy conditions" means trisomy 13, otherwise known as Patau syndrome; trisomy 18, otherwise known as Edwards syndrome; and trisomy 21, otherwise known as Down syndrome.

Subd. 3. **Health care practitioner duty.** A health care practitioner who orders tests for a pregnant woman to screen for trisomy conditions shall provide the information in

subdivision 4 to the pregnant woman if the test reveals a positive result for any of the trisomy conditions.

Subd. 4. **Commissioner duties.** (a) The commissioner shall make the following information available to health care practitioners:

(1) up-to-date and evidence-based information about the trisomy conditions that has been reviewed by medical experts and national trisomy organizations. The information must be provided in a written or an alternative format and must include the following:

(i) expected physical, developmental, educational, and psychosocial outcomes;

(ii) life expectancy;

(iii) the clinical course description;

(iv) expected intellectual and functional development; and

(v) treatment options available for the particular syndrome for which the test was positive; and

(2) contact information for nonprofit organizations that provide information and support services for trisomy conditions.

(b) The commissioner shall post the information in paragraph (a) on the Department of Health Web site.

(c) The commissioner shall follow existing department practice to ensure that the information is culturally and linguistically appropriate for all recipients.

(d) Any local or national organization that provides education or services related to trisomy conditions may request that the commissioner include the organization's informational material and contact information on the Department of Health Web site. Once a request is made, the commissioner may add the information to the Web site.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 16. Minnesota Statutes 2014, section 145.928, subdivision 13, is amended to read:

Subd. 13. ~~**Report**~~ **Reports.** (a) The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

(b) The commissioner shall submit an annual report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over public health on grants made under subdivision 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide specific information on the

amount of each grant awarded to each agency or organization, the population served by each agency or organization, outcomes of the programs funded by each grant, and the amount of the appropriation retained by the commissioner for administrative and associated expenses. The commissioner shall issue a report each January 15 for the previous fiscal year beginning January 15, 2016.

Sec. 17. **[145.9299] SMILE HEALTHY MINNESOTA 2016 GRANT PROGRAM.**

(a) The commissioner of health shall establish the Smile Healthy Minnesota 2016 grant program to provide access to dental care for at-risk children, adolescents, adults, and seniors in rural areas of Minnesota. The grant is available to nonprofit agencies that provide mobile dental care through the use of portable dental equipment. To be eligible for a grant, a provider agency must:

(1) encourage early screening and preventative care by providing dental exams for children one year of age;

(2) provide dental services to at-risk children, adolescents, adults, and seniors in a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, that is located outside the seven-county metropolitan area; and

(3) provide preventative dental care including fluoride monitoring, screenings, and minor dental treatment; and general dental care, education, and information.

(b) Grantees must report their dental health outcomes to the commissioner by December 31, 2018.

(c) Grant recipients must be organized as a nonprofit entity in Minnesota.

(d) A grantee is prohibited from billing for preventative screenings until the comprehensive oral health services are completed.

Sec. 18. Minnesota Statutes 2014, section 152.34, is amended to read:

152.34 ~~NURSING~~ HEALTH CARE FACILITIES.

~~Nursing~~ Health care facilities licensed under chapter 144A, boarding care homes licensed under section 144.50, ~~and~~ assisted living facilities, and facilities owned, controlled, managed, or under common control with hospitals licensed under chapter 144 may adopt reasonable restrictions on the use of medical cannabis by a patient enrolled in the registry program who resides at or is actively receiving treatment or care at the facility. The restrictions may include a provision that the facility will not store or maintain the patient's supply of medical cannabis, that the facility is not responsible for providing the medical cannabis for patients, and that medical cannabis be used only in a place specified

by the facility. Nothing contained in this section shall require the facilities to adopt such restrictions and no facility shall unreasonably limit a patient's access to or use of medical cannabis to the extent that use is authorized by the patient under sections 152.22 to 152.37.

Sec. 19. Minnesota Statutes 2014, section 157.15, subdivision 8, is amended to read:

Subd. 8. **Lodging establishment.** "Lodging establishment" means: (1) a building, structure, enclosure, or any part thereof used as, maintained as, advertised as, or held out to be a place where sleeping accommodations are furnished to the public as regular roomers, for periods of one week or more, and having five or more beds to let to the public.; or (2) a building, structure, or enclosure or any part thereof located within ten miles distance from a hospital or medical center and maintained as, advertised as, or held out to be a place where sleeping accommodations are furnished exclusively to patients, their families, and caregivers while the patient is receiving or waiting to receive health care treatments or procedures for periods of one week or more, and where no supportive services, as defined under section 157.17, subdivision 1, paragraph (a), or health supervision services, as defined under section 157.17, subdivision 1, paragraph (b), or home care services, as defined under section 144A.471, subdivisions 6 and 7, are provided.

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

Sec. 20. Minnesota Statutes 2014, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine ~~consultations~~ services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine ~~consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation~~ in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine ~~consultations~~ services per ~~recipient~~ enrollee per calendar week. Telemedicine ~~consultations~~ services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, chapter 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) documentation of the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) documentation of compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) If a health care provider provides the facility used as the originating site for the delivery of telemedicine to a patient, the commissioner shall make a facility fee payment to the originating site health care provider in an amount equivalent to the originated site fee paid by Medicare. No facility fee shall be paid to a health care provider that is being paid under a cost-based methodology or if Medicare has already paid the facility fee for an enrollee who is dually eligible for Medicare and medical assistance.

(e) For purposes of this subdivision, "telemedicine" is defined under section 62A.671, subdivision 9; "licensed health care provider" is defined under section 62A.671,

subdivision 6; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The criteria described in section 256B.0625, subdivision 3b, paragraph (b), shall not apply to managed care organizations and county-based purchasing plans, which may establish criteria as described in section 62A.672, subdivision 1, paragraph (b), clause (2), for the coverage of telemedicine services.

EFFECTIVE DATE. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 21. **COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.**

(a) The commissioner of human services, in consultation with representatives of emergency medical service providers, public health nurses, community health workers, the Minnesota State Fire Chiefs Association, the Minnesota Professional Firefighters Association, the Minnesota State Firefighters Department Association, Minnesota Academy of Family Physicians, Minnesota Licensed Practical Nurses Association, Minnesota Nurses Association, and local public health agencies, shall determine specified services and payment rates for these services to be performed by community medical response emergency medical technicians certified under Minnesota Statutes, section 144E.275, subdivision 7, and covered by medical assistance under Minnesota Statutes, section 256B.0625. Services may include interventions intended to prevent avoidable ambulance transportation or hospital emergency department use, care coordination, diagnosis-related patient education, and population-based preventive education.

(b) In order to be eligible for payment, services provided by a community medical response emergency medical technician must be:

(1) ordered by a medical response unit medical director;

(2) part of a patient care plan that has been developed in coordination with the patient's primary physician, advanced practice registered nurse, and relevant local health care providers; and

(3) billed by an eligible medical assistance-enrolled provider that employs or contracts with the community medical response emergency medical technician.

In determining the community medical response emergency medical technician services to include under medical assistance coverage, the commissioner of human services shall

consider the potential of hospital admittance and emergency room utilization reductions as well as increased access to quality care in rural communities.

(c) The commissioner of human services shall submit the list of services to be covered by medical assistance to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2016. These services shall not be covered by medical assistance until legislation providing coverage for the services is enacted in law.

Sec. 22. **EVALUATION OF COMMUNITY ADVANCED EMERGENCY MEDICAL TECHNICIAN SERVICES.**

If legislation is enacted to cover community advanced emergency medical technician services with medical assistance, the commissioner of human services shall evaluate the effect of medical assistance and MinnesotaCare coverage for those services on the cost and quality of care under those programs and the coordination of those services with the health care home services. The commissioner shall present findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by December 1, 2017. The commissioner shall require medical assistance- and MinnesotaCare-enrolled providers that employ or contract with community medical response emergency medical technicians to provide to the commissioner, in the form and manner specified by the commissioner, the utilization, cost, and quality data necessary to conduct this evaluation.

ARTICLE 7

CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2014, section 245C.03, is amended by adding a subdivision to read:

Subd. 10. **Providers of group residential housing or supplementary services.** The commissioner shall conduct background studies on any individual required under section 256I.04 to have a background study completed under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 2. Minnesota Statutes 2014, section 245C.10, is amended by adding a subdivision to read:

Subd. 11. **Providers of group residential housing or supplementary services.** The commissioner shall recover the cost of background studies initiated by providers of

group residential housing or supplementary services under section 256I.04 through a fee of no more than $20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 3. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision to read:

Subd. 12a. **Department of Human Services child fatality and near fatality review team.** The commissioner shall establish a Department of Human Services child fatality and near fatality review team to review child fatalities and near fatalities due to child maltreatment and child fatalities and near fatalities that occur in licensed facilities and are not due to natural causes. The review team shall assess the entire child protection services process from the point of a mandated reporter reporting the alleged maltreatment through the ongoing case management process. Department staff shall lead and conduct on-site local reviews and utilize supervisors from local county and tribal child welfare agencies as peer reviewers. The review process must focus on critical elements of the case and on the involvement of the child and family with the county or tribal child welfare agency. The review team shall identify necessary program improvement planning to address any practice issues identified and training and technical assistance needs of the local agency. Summary reports of each review shall be provided to the state child mortality review panel when completed.

Sec. 4. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision to read:

Subd. 14c. **Early intervention support and services for at-risk American Indian families.** (a) The commissioner shall authorize grants to tribal child welfare agencies and urban Indian organizations for the purpose of providing early intervention support and services to prevent child maltreatment for at-risk American Indian families.

(b) The commissioner is authorized to develop program eligibility criteria, early intervention service delivery procedures, and reporting requirements for agencies and organizations receiving grants.

Sec. 5. Minnesota Statutes 2014, section 256.017, subdivision 1, is amended to read:

Subdivision 1. **Authority and purpose.** The commissioner shall administer a compliance system for the Minnesota family investment program, the food stamp or food support program, emergency assistance, general assistance, medical assistance, emergency

general assistance, Minnesota supplemental assistance, group residential housing, preadmission screening, alternative care grants, the child care assistance program, and all other programs administered by the commissioner or on behalf of the commissioner under the powers and authorities named in section 256.01, subdivision 2. The purpose of the compliance system is to permit the commissioner to supervise the administration of public assistance programs and to enforce timely and accurate distribution of benefits, completeness of service and efficient and effective program management and operations, to increase uniformity and consistency in the administration and delivery of public assistance programs throughout the state, and to reduce the possibility of sanctions and fiscal disallowances for noncompliance with federal regulations and state statutes. The commissioner, or the commissioner's representative, may issue administrative subpoenas as needed in administering the compliance system.

The commissioner shall utilize training, technical assistance, and monitoring activities, as specified in section 256.01, subdivision 2, to encourage county agency compliance with written policies and procedures.

Sec. 6. Minnesota Statutes 2014, section 256.741, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The term "direct support" as used in this chapter and chapters 257, 518, 518A, and 518C refers to an assigned support payment from an obligor which is paid directly to a recipient of public assistance.

(b) The term "public assistance" as used in this chapter and chapters 257, 518, 518A, and 518C, includes any form of assistance provided under the AFDC program formerly codified in sections 256.72 to 256.87, MFIP and MFIP-R formerly codified under chapter 256, MFIP under chapter 256J, work first program formerly codified under chapter 256K; child care assistance provided through the child care fund under chapter 119B; any form of medical assistance under chapter 256B; ~~MinnesotaCare under chapter 256L;~~ and foster care as provided under title IV-E of the Social Security Act. MinnesotaCare and plans supplemented by tax credits are not considered public assistance for purposes of a child support referral.

(c) The term "child support agency" as used in this section refers to the public authority responsible for child support enforcement.

(d) The term "public assistance agency" as used in this section refers to a public authority providing public assistance to an individual.

(e) The terms "child support" and "arrears" as used in this section have the meanings provided in section 518A.26.

(f) The term "maintenance" as used in this section has the meaning provided in section 518.003.

Sec. 7. Minnesota Statutes 2014, section 256.741, subdivision 2, is amended to read:

Subd. 2. **Assignment of support and maintenance rights.** (a) An individual receiving public assistance in the form of assistance under any of the following programs: the AFDC program formerly codified in sections 256.72 to 256.87, MFIP under chapter 256J, MFIP-R and MFIP formerly codified under chapter 256, or work first program formerly codified under chapter 256K is considered to have assigned to the state at the time of application all rights to child support and maintenance from any other person the applicant or recipient may have in the individual's own behalf or in the behalf of any other family member for whom application for public assistance is made. An assistance unit is ineligible for the Minnesota family investment program unless the caregiver assigns all rights to child support and maintenance benefits according to this section.

(1) The assignment is effective as to any current child support and current maintenance.

(2) Any child support or maintenance arrears that accrue while an individual is receiving public assistance in the form of assistance under any of the programs listed in this paragraph are permanently assigned to the state.

(3) The assignment of current child support and current maintenance ends on the date the individual ceases to receive or is no longer eligible to receive public assistance under any of the programs listed in this paragraph.

(b) An individual receiving public assistance in the form of medical assistance~~,~~ ~~including MinnesotaCare,~~ is considered to have assigned to the state at the time of application all rights to medical support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom medical assistance is provided.

(1) An assignment made after September 30, 1997, is effective as to any medical support accruing after the date of medical assistance ~~or MinnesotaCare~~ eligibility.

(2) Any medical support arrears that accrue while an individual is receiving public assistance in the form of medical assistance~~, including MinnesotaCare,~~ are permanently assigned to the state.

(3) The assignment of current medical support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of medical assistance ~~or MinnesotaCare~~.

(c) An individual receiving public assistance in the form of child care assistance under the child care fund pursuant to chapter 119B is considered to have assigned to the state at the time of application all rights to child care support from any other person the individual may have in the individual's own behalf or in the behalf of any other family member for whom child care assistance is provided.

(1) The assignment is effective as to any current child care support.

(2) Any child care support arrears that accrue while an individual is receiving public assistance in the form of child care assistance under the child care fund in chapter 119B are permanently assigned to the state.

(3) The assignment of current child care support ends on the date the individual ceases to receive or is no longer eligible to receive public assistance in the form of child care assistance under the child care fund under chapter 119B.

Sec. 8. **[256E.28] CHILD PROTECTION GRANTS TO ADDRESS CHILD WELFARE DISPARITIES.**

Subdivision 1. **Child welfare disparities grant program established.** The commissioner may award grants to eligible entities for the development, implementation, and evaluation of activities to address racial disparities and disproportionality in the child welfare system by:

(1) identifying and addressing structural factors that contribute to inequities in outcomes;

(2) identifying and implementing strategies to reduce racial disparities in treatment and outcomes;

(3) using cultural values, beliefs, and practices of families, communities, and tribes for case planning, service design, and decision-making processes;

(4) using placement and reunification strategies to maintain and support relationships and connections between parents, siblings, children, kin, significant others, and tribes; and

(5) supporting families in the context of their communities and tribes to safely divert them from the child welfare system, whenever possible.

Subd. 2. **State-community partnerships; plan.** The commissioner, in partnership with the culturally based community organizations; the Indian Affairs Council under section 3.922; the Council on Affairs of Chicano/Latino People under section 3.9223; the Council on Black Minnesotans under section 3.9225; the Council on Asian-Pacific Minnesotans under section 3.9226; the American Indian Child Welfare Advisory Council under section 260.835; counties; and tribal governments, shall develop and implement a comprehensive, coordinated plan to award funds under this section for the priority areas

identified in subdivision 1. In developing and implementing this plan, the commissioner shall consult with the legislative task force on child protection.

Subd. 3. **Measurable outcomes.** The commissioner, in consultation with the community partners listed in subdivision 2 and the legislative task force on child protection, shall establish measurable outcomes to achieve the goals specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing disparities identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. **Process.** (a) The commissioner, in consultation with the community partners listed in subdivision 2 and the legislative task force on child protection, shall develop the criteria and procedures to allocate competitive grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. A county awarded a grant shall not spend more than three percent of the grant on administrative costs. When a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities with other entities receiving funds under this section that are in the grant recipient's service area.

(c) Grant funds must not be used to supplant any state or federal funds received for child welfare services.

Subd. 5. **Grant program criteria.** (a) The commissioner, in consultation with the legislative task force on child protection, shall award competitive grants to eligible applicants for local or regional projects and initiatives directed at reducing disparities in the child welfare system.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, counties, and tribal governments. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas in subdivision 1 and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is evidence-based;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact priority areas;

(5) reflects culturally appropriate approaches; or

(6) will be implemented through or with community-based organizations that reflect the culture of the population to be reached.

Subd. 6. **Evaluation.** (a) Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the grant program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

(b) The commissioner shall consult with the legislative task force on child protection during the evaluation process and shall submit a biennial evaluation report to the task force and to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over child protection funding.

Subd. 7. **American Indian child welfare projects.** Of the amount appropriated for purposes of this section, the commissioner shall award $75,000 to each tribe authorized to provide tribal delivery of child welfare services under section 256.01, subdivision 14b. To receive funds under this subdivision, a participating tribe is not required to apply to the commissioner for grant funds. Participating tribes are also eligible for competitive grant funds under this section.

Sec. 9. Minnesota Statutes 2014, section 256E.35, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Eligible educational institution" means the following:

(1) an institution of higher education described in section 101 or 102 of the Higher Education Act of 1965; or

(2) an area vocational education school, as defined in subparagraph (C) or (D) of United States Code, title 20, chapter 44, section 2302 (3) (the Carl D. Perkins Vocational and Applied Technology Education Act), which is located within any state, as defined in United States Code, title 20, chapter 44, section 2302 (30). This clause is applicable only to the extent section 2302 is in effect on August 1, 2008.

~~(b)~~ (c) "Family asset account" means a savings account opened by a household participating in the Minnesota family assets for independence initiative.

~~(c)~~ (d) "Fiduciary organization" means:

(1) a community action agency that has obtained recognition under section 256E.31;

(2) a federal community development credit union serving the seven-county metropolitan area; or

(3) a women-oriented economic development agency serving the seven-county metropolitan area.

(e) "Financial coach" means a person who:

(1) has completed an intensive financial literacy training workshop that includes curriculum on budgeting to increase savings, debt reduction and asset building, building a good credit rating, and consumer protection;

(2) participates in ongoing statewide family assets for independence in Minnesota (FAIM) network training meetings under FAIM program supervision; and

(3) provides financial coaching to program participants under subdivision 4a.

~~(d)~~ (f) "Financial institution" means a bank, bank and trust, savings bank, savings association, or credit union, the deposits of which are insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

(g) "Household" means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.

~~(e)~~ (h) "Permissible use" means:

(1) postsecondary educational expenses at an eligible educational institution as defined in paragraph ~~(g)~~ (b), including books, supplies, and equipment required for courses of instruction;

(2) acquisition costs of acquiring, constructing, or reconstructing a residence, including any usual or reasonable settlement, financing, or other closing costs;

(3) business capitalization expenses for expenditures on capital, plant, equipment, working capital, and inventory expenses of a legitimate business pursuant to a business plan approved by the fiduciary organization; and

(4) acquisition costs of a principal residence within the meaning of section 1034 of the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area purchase price applicable to the residence determined according to section 143(e)(2) and (3) of the Internal Revenue Code of 1986.

~~(f) "Household" means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.~~

~~(g) "Eligible educational institution" means the following:~~

~~(1) an institution of higher education described in section 101 or 102 of the Higher Education Act of 1965; or~~

~~(2) an area vocational education school, as defined in subparagraph (C) or (D) of United States Code, title 20, chapter 44, section 2302 (3) (the Carl D. Perkins Vocational and Applied Technology Education Act), which is located within any state, as defined in~~

~~United States Code, title 20, chapter 44, section 2302 (30). This clause is applicable only to the extent section 2302 is in effect on August 1, 2008.~~

Sec. 10. Minnesota Statutes 2014, section 256E.35, is amended by adding a subdivision to read:

Subd. 4a. **Financial coaching.** Within available appropriations, a financial coach shall provide the following to program participants:

(1) financial education relating to budgeting, debt reduction, asset-specific training, and financial stability activities;

(2) asset-specific training related to buying a home, acquiring postsecondary education, or starting or expanding a small business; and

(3) financial stability education and training to improve and sustain financial security.

Sec. 11. Minnesota Statutes 2014, section 256I.03, subdivision 3, is amended to read:

Subd. 3. **Group residential housing.** "Group residential housing" means a group living situation that provides at a minimum room and board to unrelated persons who meet the eligibility requirements of section 256I.04. ~~This definition includes foster care settings or community residential settings for a single adult.~~ To receive payment for a group residence rate, the residence must meet the requirements under section 256I.04, ~~subdivision~~ subdivisions 2a to 2f.

Sec. 12. Minnesota Statutes 2014, section 256I.03, subdivision 7, is amended to read:

Subd. 7. **Countable income.** "Countable income" means all income received by an applicant or recipient less any applicable exclusions or disregards. For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is ~~in a GRH~~ a recipient of group residential housing, less the medical assistance personal needs allowance under section 256B.35. If the SSI limit ~~has been~~ or benefit is reduced for a person due to events ~~occurring prior to the persons entering the GRH setting~~ other than receipt of additional income, countable income means actual income less any applicable exclusions and disregards.

Sec. 13. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 9. **Direct contact.** "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to recipients of group residential housing.

Sec. 14. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 10. **Habitability inspection.** "Habitability inspection" means an inspection to determine whether the housing occupied by an individual meets the habitability standards specified by the commissioner. The standards must be provided to the applicant in writing and posted on the Department of Human Services Web site.

Sec. 15. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 11. **Long-term homelessness.** "Long-term homelessness" means lacking a permanent place to live:

(1) continuously for one year or more; or

(2) at least four times in the past three years.

Sec. 16. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 12. **Professional certification.** "Professional certification" means a statement about an individual's illness, injury, or incapacity that is signed by a qualified professional. The statement must specify that the individual has an illness or incapacity which limits the individual's ability to work and provide self-support. The statement must also specify that the individual needs assistance to access or maintain housing, as evidenced by the need for two or more of the following services:

(1) tenancy supports to assist an individual with finding the individual's own home, landlord negotiation, securing furniture and household supplies, understanding and maintaining tenant responsibilities, conflict negotiation, and budgeting and financial education;

(2) supportive services to assist with basic living and social skills, household management, monitoring of overall well-being, and problem solving;

(3) employment supports to assist with maintaining or increasing employment, increasing earnings, understanding and utilizing appropriate benefits and services, improving physical or mental health, moving toward self-sufficiency, and achieving personal goals; or

(4) health supervision services to assist in the preparation and administration of medications other than injectables, the provision of therapeutic diets, taking vital signs, or providing assistance in dressing, grooming, bathing, or with walking devices.

Sec. 17. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 13. **Prospective budgeting.** "Prospective budgeting" means estimating the amount of monthly income a person will have in the payment month.

Sec. 18. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 14. **Qualified professional.** "Qualified professional" means an individual as defined in section 256J.08, subdivision 73a, or Minnesota Rules, part 9530.6450, subpart 3, 4, or 5; or an individual approved by the director of human services or a designee of the director.

Sec. 19. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 15. **Supportive housing.** "Supportive housing" means housing with support services according to the continuum of care coordinated assessment system established under Code of Federal Regulations, title 24, section 578.3.

Sec. 20. Minnesota Statutes 2014, section 256I.04, is amended to read:

256I.04 ELIGIBILITY FOR GROUP RESIDENTIAL HOUSING PAYMENT.

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

(a) The individual is aged, blind, or is over 18 years of age and disabled as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of group residential housing in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and

the individual's countable income as determined under sections 256D.01 to 256D.21, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of group residential housing in which the individual resides.

Subd. 1a. **County approval.** (a) A county agency may not approve a group residential housing payment for an individual in any setting with a rate in excess of the MSA equivalent rate for more than 30 days in a calendar year unless the ~~county agency has developed or approved~~ individual has a ~~plan for the individual which specifies that:~~

~~(1) the individual has an illness or incapacity which prevents the person from living independently in the community; and~~

~~(2) the individual's illness or incapacity requires the services which are available in the group residence.~~

~~The plan must be signed or countersigned by any of the following employees of the county of financial responsibility: the director of human services or a designee of the director; a social worker; or a case aide~~ professional certification under section 256I.03, subdivision 12.

(b) If a county agency determines that an applicant is ineligible due to not meeting eligibility requirements under this section, a county agency may accept a signed personal statement from the applicant in lieu of documentation verifying ineligibility.

(c) Effective July 1, 2016, to be eligible for supplementary service payments, providers must enroll in the provider enrollment system identified by the commissioner.

Subd. 1b. **Optional state supplements to SSI.** Group residential housing payments made on behalf of persons eligible under subdivision 1, paragraph (a), are optional state supplements to the SSI program.

Subd. 1c. **Interim assistance.** Group residential housing payments made on behalf of persons eligible under subdivision 1, paragraph (b), are considered interim assistance payments to applicants for the federal SSI program.

Subd. 2. **Date of eligibility.** An individual who has met the eligibility requirements of subdivision 1, shall have a group residential housing payment made on the individual's behalf from the first day of the month in which a signed application form is received by a county agency, or the first day of the month in which all eligibility factors have been met, whichever is later.

Subd. 2a. **License required; staffing qualifications.** ~~A county~~ (a) Except as provided in paragraph (b), an agency may not enter into an agreement with an establishment to provide group residential housing unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; ~~a residential care home;~~ a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; (iii) ~~a residence~~ licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02, subdivision 4a, as a community residential setting by the commissioner of human services; or

(3) the establishment is registered under chapter 144D and provides three meals a day, or is an establishment voluntarily registered under section 144D.025 as a supportive housing establishment~~; or~~.

~~(4) an establishment voluntarily registered under section 144D.025, other than a supportive housing establishment under clause (3), is not eligible to provide group residential housing.~~

(b) The requirements under ~~clauses (1) to (4)~~ paragraph (a) do not apply to establishments exempt from state licensure because they are:

(1) located on Indian reservations and subject to tribal health and safety requirements~~.~~; or

(2) a supportive housing establishment that has an approved habitability inspection and an individual lease agreement and that serves people who have experienced long-term homelessness and were referred through a coordinated assessment in section 256I.03, subdivision 15.

(c) Supportive housing establishments and emergency shelters must participate in the homeless management information system.

(d) Effective July 1, 2016, an agency shall not have an agreement with a provider of group residential housing or supplementary services unless all staff members who have direct contact with recipients:

(1) have skills and knowledge acquired through one or more of the following:

(i) a course of study in a health- or human services-related field leading to a bachelor of arts, bachelor of science, or associate's degree;

(ii) one year of experience with the target population served;

(iii) experience as a certified peer specialist according to section 256B.0615; or

(iv) meeting the requirements for unlicensed personnel under sections 144A.43 to 144A.483;

(2) hold a current Minnesota driver's license appropriate to the vehicle driven if transporting recipients;

(3) complete training on vulnerable adults mandated reporting and child maltreatment mandated reporting, where applicable; and

(4) complete group residential housing orientation training offered by the commissioner.

Subd. 2b. **Group residential housing agreements.** (a) Agreements between ~~county~~ agencies and providers of group residential housing must be in writing on a form developed and approved by the commissioner and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from group residential housing funds for each eligible resident at each location; the number of beds at each location which are subject to the group residential housing agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

(b) Providers are required to verify the following minimum requirements in the agreement:

(1) current license or registration, including authorization if managing or monitoring medications;

(2) all staff who have direct contact with recipients meet the staff qualifications;

(3) the provision of group residential housing;

(4) the provision of supplementary services, if applicable;

(5) reports of adverse events, including recipient death or serious injury; and

(6) submission of residency requirements that could result in recipient eviction.

~~Group residential housing~~ (c) Agreements may be terminated with or without cause by ~~either~~ the ~~county~~ commissioner, the agency, or the provider with two calendar months prior notice. The commissioner may immediately terminate an agreement under subdivision 2d.

Subd. 2c. **~~Crisis shelters~~ Background study requirements.** ~~Secure crisis shelters for battered women and their children designated by the Minnesota Department of Corrections are not group residences under this chapter.~~ (a) Effective July 1, 2016, a provider of group residential housing or supplementary services must initiate background studies in accordance with chapter 245C of the following individuals:

(1) controlling individuals as defined in section 245A.02;

(2) managerial officials as defined in section 245A.02; and

(3) all employees and volunteers of the establishment who have direct contact with recipients, or who have unsupervised access to recipients, their personal property, or their private data.

(b) The provider of group residential housing or supplementary services must maintain compliance with all requirements established for entities initiating background studies under chapter 245C.

(c) Effective July 1, 2017, a provider of group residential housing or supplementary services must demonstrate that all individuals required to have a background study according to paragraph (a) have a notice stating either that:

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

(2) the individual is disqualified, but the individual has been issued a set-aside of the disqualification for that setting under section 245C.22.

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

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

(c) Notwithstanding paragraph (b), if the commissioner learns of a curable material breach of the agreement by the provider, the commissioner shall provide the provider

with a written notice of the breach and allow ten days to cure the breach. If the provider does not cure the breach within the time allowed, the provider shall be in default of the agreement and the commissioner may terminate the agreement immediately thereafter. If the provider has breached a material term of the agreement and cure is not possible, the commissioner may immediately terminate the agreement.

Subd. 2e. **Providers holding health or human services licenses.** (a) Except for facilities with only a board and lodging license, when group residential housing or supplementary service staff are also operating under a license issued by the Department of Health or the Department of Human Services, the minimum staff qualification requirements for the setting shall be the qualifications listed under the related licensing standards.

(b) A background study completed for the licensed service must also satisfy the background study requirements under this section, if the provider has established the background study contact person according to chapter 245C and as directed by the Department of Human Services.

Subd. 2f. **Required services.** In licensed and registered settings under subdivision 2a, providers shall ensure that participants have at a minimum:

(1) food preparation and service for three nutritional meals a day on site;

(2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

(3) housekeeping, including cleaning and lavatory supplies or service; and

(4) maintenance and operation of the building and grounds, including heat, water, garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair and maintain equipment and facilities.

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

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

(1) for group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991,

in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(3) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

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

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

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

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

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

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

Subd. 4. **Rental assistance.** For participants in the Minnesota supportive housing demonstration program under subdivision 3, paragraph (a), clause (5), notwithstanding the provisions of section 256I.06, subdivision 8, the amount of the group residential housing payment for room and board must be calculated by subtracting 30 percent of the recipient's adjusted income as defined by the United States Department of Housing and Urban Development for the Section 8 program from the fair market rent established for the recipient's living unit by the federal Department of Housing and Urban Development. This payment shall be regarded as a state housing subsidy for the purposes of subdivision 3. Notwithstanding the provisions of section 256I.06, subdivision 6, the recipient's countable income will only be adjusted when a change of greater than $100 in a month occurs or upon annual redetermination of eligibility, whichever is sooner. ~~The commissioner is directed to study the feasibility of developing a rental assistance program to serve persons traditionally served in group residential housing settings and report to the legislature by February 15, 1999.~~

EFFECTIVE DATE. Subdivision 1, paragraph (b), is effective September 1, 2015.

Sec. 21. Minnesota Statutes 2014, section 256I.05, subdivision 1c, is amended to read:

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

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

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

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

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

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

(f) Until June 30, 1994, ~~a county~~ an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0050 to 9549.0058.

Sec. 22. Minnesota Statutes 2014, section 256I.05, subdivision 1g, is amended to read:

Subd. 1g. **Supplementary service rate for certain facilities.** ~~On or after July 1, 2005, a county~~ An agency may negotiate a supplementary service rate for recipients of assistance under section 256I.04, subdivision 1, paragraph (a) or (b), who ~~relocate from a homeless shelter licensed and registered prior to December 31, 1996, by the Minnesota Department of Health under section 157.17, to~~ have experienced long-term homelessness and who live in a supportive housing establishment ~~developed and funded in whole or in part with funds provided specifically as part of the plan to end long-term homelessness required under Laws 2003, chapter 128, article 15, section 9, not to exceed $456.75~~ under section 256I.04, subdivision 2a, paragraph (b), clause (2).

Sec. 23. Minnesota Statutes 2014, section 256I.06, subdivision 2, is amended to read:

Subd. 2. **Time of payment.** A county agency may make payments to a group residence in advance for an individual whose stay in the group residence is expected to last beyond the calendar month for which the payment is made ~~and who does not expect to receive countable earned income during the month for which the payment is made~~. Group residential housing payments made by a county agency on behalf of an individual who is not expected to remain in the group residence beyond the month for which payment is made must be made subsequent to the individual's departure from the group residence. ~~Group residential housing payments made by a county agency on behalf of an individual with countable earned income must be made subsequent to receipt of a monthly household report form.~~

EFFECTIVE DATE. This section is effective April 1, 2016.

Sec. 24. Minnesota Statutes 2014, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances that affect eligibility or group residential housing payment amounts, other than changes in earned income, within ten days of the change. Recipients with countable earned income must complete a ~~monthly~~ household report form at least once every six months. If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for group residential housing payments. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for group residential housing payment effective the first day of the month the eligibility was terminated.

EFFECTIVE DATE. This section is effective April 1, 2016.

Sec. 25. Minnesota Statutes 2014, section 256I.06, subdivision 7, is amended to read:

Subd. 7. **Determination of rates.** The agency in the county in which a ~~group~~ residence is located ~~will~~ shall determine the amount of group residential housing rate to be paid on behalf of an individual in the ~~group~~ residence regardless of the individual's ~~county~~ agency of financial responsibility.

Sec. 26. Minnesota Statutes 2014, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of group residential housing payment.** (a) The amount of a group residential housing payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the group residential housing charge for that same month. The group residential housing charge is determined by multiplying the group residential housing rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

EFFECTIVE DATE. Paragraph (b) is effective April 1, 2016.

Sec. 27. Minnesota Statutes 2014, section 256K.45, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** (a) The definitions in this subdivision apply to this section.

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

(c) "Homeless youth" means a person ~~21~~ 24 years of age or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available, whose parent or legal guardian is unable or unwilling to provide shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution or a publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Homeless youth does not include persons incarcerated or otherwise detained under federal or state law.

(d) "Youth at risk of homelessness" means a person ~~21~~ 24 years of age or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. Status or circumstances that indicate a significant danger may include: (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3) youth whose parents or primary caregivers are or were previously homeless; (4) youth who are exposed to abuse and neglect in their homes; (5) youth who experience conflict with parents due to chemical or alcohol dependency, mental health disabilities, or other disabilities; and (6) runaways.

(e) "Runaway" means an unmarried child under the age of 18 years who is absent from the home of a parent or guardian or other lawful placement without the consent of the parent, guardian, or lawful custodian.

Sec. 28. **[256M.41] CHILD PROTECTION GRANT ALLOCATION.**

Subdivision 1. **Formula for county staffing funds.** The commissioner shall allocate state funds appropriated under this section to each county board on a calendar year basis in an amount determined according to the following formula:

(1) 25 percent must be distributed on the basis of the number of screened-out reports of child maltreatment under sections 626.556 and 626.5561, and in the county as determined by the most recent data of the commissioner;

(2) 25 percent must be distributed on the basis of the number of screened-in reports of child maltreatment under sections 626.556 and 626.5561, and in the county as determined by the most recent data of the commissioner; and

(3) 50 percent must be distributed on the basis of the number of open child protection case management cases in the county as determined by the most recent data of the commissioner.

Subd. 2. **Prohibition on supplanting existing funds.** Funds received under this section must be used to address staffing for child protection or expand child protection services. Funds must not be used to supplant current county expenditures for these purposes.

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

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

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

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

(3) ten percent of the allocation shall be withheld until the commissioner determines that the county has met the performance outcome threshold of 90 percent based on face-to-face visits by the case manager. In order to receive the performance allocation, the total number of visits made by caseworkers on a monthly basis to children in foster care and children receiving child protection services while residing in their home must be at least 90 percent of the total number of such visits that would occur if every child were visited once per month. The commissioner shall make such determinations in January of each year and payments to counties meeting the performance outcome threshold shall occur in February of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be reallocated by the commissioner to those counties meeting the requirement.

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

Sec. 29. Minnesota Statutes 2014, section 256N.22, subdivision 9, is amended to read:

Subd. 9. **Death or incapacity of relative custodian or ~~dissolution~~ modification of custody.** The Northstar kinship assistance agreement ends upon death or ~~dissolution~~ incapacity of the relative custodian or modification of the order for permanent legal and physical custody ~~of both relative custodians in the case of assignment of custody to two individuals, or the sole relative custodian in the case of assignment of custody to one individual~~ in which legal or physical custody is removed from the relative custodian. In the case of a relative custodian's death or incapacity, Northstar kinship assistance eligibility may be continued according to subdivision 10.

Sec. 30. Minnesota Statutes 2014, section 256N.22, subdivision 10, is amended to read:

Subd. 10. **Assigning a successor relative custodian for a child's Northstar kinship assistance ~~to a court-appointed guardian or custodian.~~** (a) ~~Northstar kinship assistance may be continued with the written consent of the commissioner to~~ In the event of the death or incapacity of the relative custodian, eligibility for Northstar kinship assistance and title IV-E assistance, if applicable, is not affected if the relative custodian is replaced by a successor named in the Northstar kinship assistance benefit agreement. Northstar kinship assistance shall be paid to a named successor who is not the child's legal parent, biological parent, or stepparent, or other adult living in the home of the legal parent, biological parent, or stepparent.

(b) In order to receive Northstar kinship assistance, a named successor must:

(1) meet the background study requirements in subdivision 4;

(2) renegotiate the agreement consistent with section 256N.25, subdivision 2, including cooperating with an assessment under section 256N.24;

(3) be ordered by the court to be the child's legal relative custodian in a modification proceeding under section 260C.521, subdivision 2; and

(4) satisfy the requirements in this paragraph within one year of the relative custodian's death or incapacity unless the commissioner certifies that the named successor made reasonable attempts to satisfy the requirements within one year and failure to satisfy the requirements was not the responsibility of the named successor.

(c) Payment of Northstar kinship assistance to the successor guardian may be temporarily approved through the policies, procedures, requirements, and deadlines under section 256N.28, subdivision 2. Ongoing payment shall begin in the month when all the requirements in paragraph (b) are satisfied.

(d) Continued payment of Northstar kinship assistance may occur in the event of the death or incapacity of the relative custodian when no successor has been named in the

benefit agreement when the commissioner gives written consent to an individual who is a guardian or custodian appointed by a court for the child upon the death of both relative custodians in the case of assignment of custody to two individuals, or the sole relative custodian in the case of assignment of custody to one individual, unless the child is under the custody of a county, tribal, or child-placing agency.

~~(b)~~ (e) Temporary assignment of Northstar kinship assistance may be approved for a maximum of six consecutive months from the death or incapacity of the relative custodian or custodians as provided in paragraph (a) and must adhere to the policies ~~and~~, procedures, requirements, and deadlines under section 256N.28, subdivision 2, that are prescribed by the commissioner. If a court has not appointed a permanent legal guardian or custodian within six months, the Northstar kinship assistance must terminate and must not be resumed.

~~(c)~~ (f) Upon assignment of assistance payments under ~~this subdivision~~ paragraphs (d) and (e), assistance must be provided from funds other than title IV-E.

Sec. 31. Minnesota Statutes 2014, section 256N.24, subdivision 4, is amended to read:

Subd. 4. **Extraordinary levels.** (a) The assessment tool established under subdivision 2 must provide a mechanism through which up to five levels can be added to the supplemental difficulty of care for a particular child under section 256N.26, subdivision 4. In establishing the assessment tool, the commissioner must design the tool so that the levels applicable to the portions of the assessment other than the extraordinary levels can accommodate the requirements of this subdivision.

(b) These extraordinary levels are available when all of the following circumstances apply:

(1) the child has extraordinary needs as determined by the assessment tool provided for under subdivision 2, and the child meets other requirements established by the commissioner, such as a minimum score on the assessment tool;

(2) the child's extraordinary needs require extraordinary care and intense supervision that is provided by the child's caregiver as part of the parental duties as described in the supplemental difficulty of care rate, section 256N.02, subdivision 21. This extraordinary care provided by the caregiver is required so that the child can be safely cared for in the home and community, and prevents residential placement;

(3) the child is physically living in a foster family setting, as defined in Minnesota Rules, part 2960.3010, subpart 23, in a foster residence setting, or physically living in the home with the adoptive parent or relative custodian; and

(4) the child is receiving the services for which the child is eligible through medical assistance programs or other programs that provide necessary services for children with disabilities or other medical and behavioral conditions to live with the child's family, but the agency with caregiver's input has identified a specific support gap that cannot be met through home and community support waivers or other programs that are designed to provide support for children with special needs.

(c) The agency completing an assessment, under subdivision 2, that suggests an extraordinary level must document as part of the assessment, the following:

(1) the assessment tool that determined that the child's needs or disabilities require extraordinary care and intense supervision;

(2) a summary of the extraordinary care and intense supervision that is provided by the caregiver as part of the parental duties as described in the supplemental difficulty of care rate, section 256N.02, subdivision 21;

(3) confirmation that the child is currently physically residing in the foster family setting or in the home with the adoptive parent or relative custodian;

(4) the efforts of the agency, caregiver, parents, and others to request support services in the home and community that would ease the degree of parental duties provided by the caregiver for the care and supervision of the child. This would include documentation of the services provided for the child's needs or disabilities, and the services that were denied or not available from the local social service agency, community agency, the local school district, local public health department, the parent, or child's medical insurance provider;

(5) the specific support gap identified that places the child's safety and well-being at risk in the home or community and is necessary to prevent residential placement; and

(6) the extraordinary care and intense supervision provided by the foster, adoptive, or guardianship caregivers to maintain the child safely in the child's home and prevent residential placement that cannot be supported by medical assistance or other programs that provide services, necessary care for children with disabilities, or other medical or behavioral conditions in the home or community.

(d) An agency completing an assessment under subdivision 2 that suggests an extraordinary level is appropriate must forward the assessment and required documentation to the commissioner. If the commissioner approves, the extraordinary levels must be retroactive to the date the assessment was forwarded.

Sec. 32. Minnesota Statutes 2014, section 256N.25, subdivision 1, is amended to read:

Subdivision 1. **Agreement; Northstar kinship assistance; adoption assistance.** (a) In order to receive Northstar kinship assistance or adoption assistance benefits on behalf

of an eligible child, a written, binding agreement between the caregiver or caregivers, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, and the commissioner must be established prior to finalization of the adoption or a transfer of permanent legal and physical custody. The agreement must be negotiated with the caregiver or caregivers under subdivision 2 and renegotiated under subdivision 3, if applicable.

(b) The agreement must be on a form approved by the commissioner and must specify the following:

(1) duration of the agreement;

(2) the nature and amount of any payment, services, and assistance to be provided under such agreement;

(3) the child's eligibility for Medicaid services;

(4) the terms of the payment, including any child care portion as specified in section 256N.24, subdivision 3;

(5) eligibility for reimbursement of nonrecurring expenses associated with adopting or obtaining permanent legal and physical custody of the child, to the extent that the total cost does not exceed $2,000 per child;

(6) that the agreement must remain in effect regardless of the state of which the adoptive parents or relative custodians are residents at any given time;

(7) provisions for modification of the terms of the agreement, including renegotiation of the agreement; ~~and~~

(8) the effective date of the agreement; and

(9) the successor relative custodian or custodians for Northstar kinship assistance, when applicable. The successor relative custodian or custodians may be added or changed by mutual agreement under subdivision 3.

(c) The caregivers, the commissioner, and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must sign the agreement. A copy of the signed agreement must be given to each party. Once signed by all parties, the commissioner shall maintain the official record of the agreement.

(d) The effective date of the Northstar kinship assistance agreement must be the date of the court order that transfers permanent legal and physical custody to the relative. The effective date of the adoption assistance agreement is the date of the finalized adoption decree.

(e) Termination or disruption of the preadoptive placement or the foster care placement prior to assignment of custody makes the agreement with that caregiver void.

Sec. 33. Minnesota Statutes 2014, section 256N.27, subdivision 2, is amended to read:

Subd. 2. **State share.** The commissioner shall pay the state share of the maintenance payments as determined under subdivision 4, and an identical share of the pre-Northstar Care foster care program under section 260C.4411, subdivision 1, the relative custody assistance program under section 257.85, and the pre-Northstar Care for Children adoption assistance program under chapter 259A. ~~The commissioner may transfer funds into the account if a deficit occurs.~~

Sec. 34. Minnesota Statutes 2014, section 257.75, subdivision 3, is amended to read:

Subd. 3. **Effect of recognition.** (a) Subject to subdivision 2 and section 257.55, subdivision 1, paragraph (g) or (h), the recognition has the force and effect of a judgment or order determining the existence of the parent and child relationship under section 257.66. If the conditions in section 257.55, subdivision 1, paragraph (g) or (h), exist, the recognition creates only a presumption of paternity for purposes of sections 257.51 to 257.74. Once a recognition has been properly executed and filed with the state registrar of vital statistics, if there are no competing presumptions of paternity, a judicial or administrative court may not allow further action to determine parentage regarding the signator of the recognition. An action to determine custody and parenting time may be commenced pursuant to chapter 518 without an adjudication of parentage. Until ~~an~~ a temporary or permanent order is entered granting custody to another, the mother has sole custody.

(b) Following commencement of an action to determine custody or parenting time under chapter 518, the court may, pursuant to section 518.131, grant temporary parenting time rights and temporary custody to either parent.

(c) The recognition is:

(1) a basis for bringing an action for the following:

(i) to award temporary custody or parenting time pursuant to section 518.131;

(ii) to award permanent custody or parenting time to either parent~~,~~;

(iii) establishing a child support obligation which may include up to the two years immediately preceding the commencement of the action~~,~~;

(iv) ordering a contribution by a parent under section 256.87~~, or~~;

(v) ordering a contribution to the reasonable expenses of the mother's pregnancy and confinement, as provided under section 257.66, subdivision 3~~,~~; or

(vi) ordering reimbursement for the costs of blood or genetic testing, as provided under section 257.69, subdivision 2;

(2) determinative for all other purposes related to the existence of the parent and child relationship; and

(3) entitled to full faith and credit in other jurisdictions.

Sec. 35. Minnesota Statutes 2014, section 257.75, subdivision 5, is amended to read:

Subd. 5. **Recognition form.** (a) The commissioner of human services shall prepare a form for the recognition of parentage under this section. In preparing the form, the commissioner shall consult with the individuals specified in subdivision 6. The recognition form must be drafted so that the force and effect of the recognition, the alternatives to executing a recognition, ~~and~~ the benefits and responsibilities of establishing paternity, and the limitations of the recognition of parentage for purposes of exercising and enforcing custody or parenting time are clear and understandable. ~~The form must include a notice regarding the finality of a recognition and the revocation procedure under subdivision 2. The form must include a provision for each parent to verify that the parent has read or viewed the educational materials prepared by the commissioner of human services describing the recognition of paternity. The individual providing the form to the parents for execution shall provide oral notice of the rights, responsibilities, and alternatives to executing the recognition. Notice may be provided by audiotape, videotape, or similar means. Each parent must receive a copy of the recognition.~~

(b) The form must include the following:

(1) a notice regarding the finality of a recognition and the revocation procedure under subdivision 2;

(2) a notice, in large print, that the recognition does not establish an enforceable right to legal custody, physical custody, or parenting time until such rights are awarded pursuant to a court action to establish custody and parenting time;

(3) a notice stating that when a court awards custody and parenting time under chapter 518, there is no presumption for or against joint physical custody, except when domestic abuse, as defined in section 518B.01, subdivision 2, paragraph (a), has occurred between the parties;

(4) a notice that the recognition of parentage is a basis for:

(i) bringing a court action to award temporary or permanent custody or parenting time;

(ii) establishing a child support obligation that may include the two years immediately preceding the commencement of the action;

(iii) ordering a contribution by a parent under section 256.87;

(iv) ordering a contribution to the reasonable expenses of the mother's pregnancy and confinement, as provided under section 257.66, subdivision 3; and

(v) ordering reimbursement for the costs of blood or genetic testing, as provided under section 257.69, subdivision 2; and

(5) a provision for each parent to verify that the parent has read or viewed the educational materials prepared by the commissioner of human services describing the recognition of paternity.

(c) The individual providing the form to the parents for execution shall provide oral notice of the rights, responsibilities, and alternatives to executing the recognition. Notice may be provided in audio or video format, or by other similar means. Each parent must receive a copy of the recognition.

Sec. 36. Minnesota Statutes 2014, section 259A.75, is amended to read:

259A.75 REIMBURSEMENT OF CERTAIN AGENCY COSTS; PURCHASE OF SERVICE CONTRACTS AND TRIBAL CUSTOMARY ADOPTIONS.

Subdivision 1. **General information.** (a) Subject to the procedures required by the commissioner and the provisions of this section, a Minnesota county ~~or tribal social services agency~~ shall receive a reimbursement from the commissioner equal to 100 percent of the reasonable and appropriate cost for contracted adoption placement services identified for a specific child that are not reimbursed under other federal or state funding sources.

(b) The commissioner may spend up to $16,000 for each purchase of service contract. Only one contract per child per adoptive placement is permitted. Funds encumbered and obligated under the contract for the child remain available until the terms of the contract are fulfilled or the contract is terminated.

(c) The commissioner shall set aside an amount not to exceed five percent of the total amount of the fiscal year appropriation from the state for the adoption assistance program to reimburse a Minnesota county or tribal social services placing ~~agencies~~ agency for child-specific adoption placement services. When adoption assistance payments for children's needs exceed 95 percent of the total amount of the fiscal year appropriation from the state for the adoption assistance program, the amount of reimbursement available to placing agencies for adoption services is reduced correspondingly.

Subd. 2. **Purchase of service contract child eligibility criteria.** (a) A child who is the subject of a purchase of service contract must:

(1) have the goal of adoption, which may include an adoption in accordance with tribal law;

(2) be under the guardianship of the commissioner of human services or be a ward of tribal court pursuant to section 260.755, subdivision 20; and

(3) meet all of the special needs criteria according to section 259A.10, subdivision 2.

(b) A child under the guardianship of the commissioner must have an identified adoptive parent and a fully executed adoption placement agreement according to section 260C.613, subdivision 1, paragraph (a).

Subd. 3. **Agency eligibility criteria.** (a) A Minnesota county ~~or tribal~~ social services agency shall receive reimbursement for child-specific adoption placement services for an eligible child that it purchases from a private adoption agency licensed in Minnesota or any other state or tribal social services agency.

(b) Reimbursement for adoption services is available only for services provided prior to the date of the adoption decree.

Subd. 4. **Application and eligibility determination.** (a) A county ~~or tribal~~ social services agency may request reimbursement of costs for adoption placement services by submitting a complete purchase of service application, according to the requirements and procedures and on forms prescribed by the commissioner.

(b) The commissioner shall determine eligibility for reimbursement of adoption placement services. If determined eligible, the commissioner of human services shall sign the purchase of service agreement, making this a fully executed contract. No reimbursement under this section shall be made to an agency for services provided prior to the fully executed contract.

(c) Separate purchase of service agreements shall be made, and separate records maintained, on each child. Only one agreement per child per adoptive placement is permitted. For siblings who are placed together, services shall be planned and provided to best maximize efficiency of the contracted hours.

Subd. 5. **Reimbursement process.** (a) The agency providing adoption services is responsible to track and record all service activity, including billable hours, on a form prescribed by the commissioner. The agency shall submit this form to the state for reimbursement after services have been completed.

(b) The commissioner shall make the final determination whether or not the requested reimbursement costs are reasonable and appropriate and if the services have been completed according to the terms of the purchase of service agreement.

Subd. 6. **Retention of purchase of service records.** Agencies entering into purchase of service contracts shall keep a copy of the agreements, service records, and all applicable billing and invoicing according to the department's record retention schedule. Agency records shall be provided upon request by the commissioner.

Subd. 7. **Tribal customary adoptions.** (a) The commissioner shall enter into grant contracts with Minnesota tribal social services agencies to provide child-specific

recruitment and adoption placement services for Indian children under the jurisdiction of tribal court.

(b) Children served under these grant contracts must meet the child eligibility criteria in subdivision 2.

Sec. 37. Minnesota Statutes 2014, section 260C.007, subdivision 27, is amended to read:

Subd. 27. **Relative.** "Relative" means a person related to the child by blood, marriage, or adoption~~,~~; the legal parent, guardian, or custodian of the child's siblings; or an individual who is an important friend with whom the child has resided or had significant contact. For an Indian child, relative includes members of the extended family as defined by the law or custom of the Indian child's tribe or, in the absence of law or custom, nieces, nephews, or first or second cousins, as provided in the Indian Child Welfare Act of 1978, United States Code, title 25, section 1903.

Sec. 38. Minnesota Statutes 2014, section 260C.007, subdivision 32, is amended to read:

Subd. 32. **Sibling.** "Sibling" means one of two or more individuals who have one or both parents in common through blood, marriage, or adoption~~, including~~. This includes siblings as defined by the child's tribal code or custom. Sibling also includes an individual who would have been considered a sibling but for a termination of parental rights of one or both parents, suspension of parental rights under tribal code, or other disruption of parental rights such as the death of a parent.

Sec. 39. Minnesota Statutes 2014, section 260C.203, is amended to read:

260C.203 ADMINISTRATIVE OR COURT REVIEW OF PLACEMENTS.

(a) Unless the court is conducting the reviews required under section 260C.202, there shall be an administrative review of the out-of-home placement plan of each child placed in foster care no later than 180 days after the initial placement of the child in foster care and at least every six months thereafter if the child is not returned to the home of the parent or parents within that time. The out-of-home placement plan must be monitored and updated at each administrative review. The administrative review shall be conducted by the responsible social services agency using a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review. The administrative review shall be open to participation by the parent or guardian of the child and the child, as appropriate.

(b) As an alternative to the administrative review required in paragraph (a), the court may, as part of any hearing required under the Minnesota Rules of Juvenile Protection

Procedure, conduct a hearing to monitor and update the out-of-home placement plan pursuant to the procedure and standard in section 260C.201, subdivision 6, paragraph (d). The party requesting review of the out-of-home placement plan shall give parties to the proceeding notice of the request to review and update the out-of-home placement plan. A court review conducted pursuant to section 260C.141, subdivision 2; 260C.193; 260C.201, subdivision 1; 260C.202; 260C.204; 260C.317; or 260D.06 shall satisfy the requirement for the review so long as the other requirements of this section are met.

(c) As appropriate to the stage of the proceedings and relevant court orders, the responsible social services agency or the court shall review:

(1) the safety, permanency needs, and well-being of the child;

(2) the continuing necessity for and appropriateness of the placement;

(3) the extent of compliance with the out-of-home placement plan;

(4) the extent of progress that has been made toward alleviating or mitigating the causes necessitating placement in foster care;

(5) the projected date by which the child may be returned to and safely maintained in the home or placed permanently away from the care of the parent or parents or guardian; and

(6) the appropriateness of the services provided to the child.

(d) When a child is age ~~16~~ 14 or older, in addition to any administrative review conducted by the agency, at the in-court review required under section 260C.317, subdivision 3, clause (3), or 260C.515, subdivision 5 or 6, the court shall review the independent living plan required under section 260C.212, subdivision 1, paragraph (c), clause ~~(11)~~ (12), and the provision of services to the child related to the well-being of the child as the child prepares to leave foster care. The review shall include the actual plans related to each item in the plan necessary to the child's future safety and well-being when the child is no longer in foster care.

(e) At the court review required under paragraph (d) for a child age ~~16~~ 14 or older, the following procedures apply:

(1) six months before the child is expected to be discharged from foster care, the responsible social services agency shall give the written notice required under section 260C.451, subdivision 1, regarding the right to continued access to services for certain children in foster care past age 18 and of the right to appeal a denial of social services under section 256.045. The agency shall file a copy of the notice, including the right to appeal a denial of social services, with the court. If the agency does not file the notice by the time the child is age 17-1/2, the court shall require the agency to give it;

(2) consistent with the requirements of the independent living plan, the court shall review progress toward or accomplishment of the following goals:

(i) the child has obtained a high school diploma or its equivalent;

(ii) the child has completed a driver's education course or has demonstrated the ability to use public transportation in the child's community;

(iii) the child is employed or enrolled in postsecondary education;

(iv) the child has applied for and obtained postsecondary education financial aid for which the child is eligible;

(v) the child has health care coverage and health care providers to meet the child's physical and mental health needs;

(vi) the child has applied for and obtained disability income assistance for which the child is eligible;

(vii) the child has obtained affordable housing with necessary supports, which does not include a homeless shelter;

(viii) the child has saved sufficient funds to pay for the first month's rent and a damage deposit;

(ix) the child has an alternative affordable housing plan, which does not include a homeless shelter, if the original housing plan is unworkable;

(x) the child, if male, has registered for the Selective Service; and

(xi) the child has a permanent connection to a caring adult; and

(3) the court shall ensure that the responsible agency in conjunction with the placement provider assists the child in obtaining the following documents prior to the child's leaving foster care: a Social Security card; the child's birth certificate; a state identification card or driver's license, tribal enrollment identification card, green card, or school visa; the child's school, medical, and dental records; a contact list of the child's medical, dental, and mental health providers; and contact information for the child's siblings, if the siblings are in foster care.

(f) For a child who will be discharged from foster care at age 18 or older, the responsible social services agency is required to develop a personalized transition plan as directed by the youth. The transition plan must be developed during the 90-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the child may elect and include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and work force supports and employment services. The agency shall ensure that the youth receives, at no cost to the youth, a copy of the youth's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report. The plan must include information on the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable

to participate in these decisions and the child does not have, or does not want, a relative who would otherwise be authorized to make these decisions. The plan must provide the child with the option to execute a health care directive as provided under chapter 145C. The agency shall also provide the youth with appropriate contact information if the youth needs more information or needs help dealing with a crisis situation through age 21.

Sec. 40. Minnesota Statutes 2014, section 260C.212, subdivision 1, is amended to read:

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

(b) An out-of-home placement plan means a written document which is prepared by the responsible social services agency jointly with the parent or parents or guardian of the child and in consultation with the child's guardian ad litem, the child's tribe, if the child is an Indian child, the child's foster parent or representative of the foster care facility, and, where appropriate, the child. When a child is age 14 or older, the child may include two other individuals on the team preparing the child's out-of-home placement plan. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. As appropriate, the plan shall be:

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

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

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

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

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

(2) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the

parent or parents which necessitated removal of the child from home and the changes the parent or parents must make in order for the child to safely return home;

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

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

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

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

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

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize adoption as the permanency plan for the child~~, including: (i)~~ through reasonable efforts to place the child for adoption. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child, child-specific recruitment efforts such as relative search and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b); ~~and~~

~~(ii) documentation necessary to support the requirements of the kinship placement agreement under section 256N.22 when adoption is determined not to be in the child's best interests;~~ (7) when a child cannot return to or be in the care of either parent, documentation of steps to finalize the transfer of permanent legal and physical custody to a relative as the permanency plan for the child. This documentation must support the requirements of the kinship placement agreement under section 256N.22 and must include the reasonable efforts used to determine that it is not appropriate for the child to return home or be adopted, and reasons why permanent placement with a relative through a Northstar kinship assistance arrangement is in the child's best interest; how the child meets

the eligibility requirements for Northstar kinship assistance payments; agency efforts to discuss adoption with the child's relative foster parent and reasons why the relative foster parent chose not to pursue adoption, if applicable; and agency efforts to discuss with the child's parent or parents the permanent transfer of permanent legal and physical custody or the reasons why these efforts were not made;

~~(7)~~ (8) efforts to ensure the child's educational stability while in foster care, including:

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

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

~~(8)~~ (9) the educational records of the child including the most recent information available regarding:

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

(ii) the child's grade level performance;

(iii) the child's school record;

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

(v) any other relevant educational information;

~~(9)~~ (10) the efforts by the local agency to ensure the oversight and continuity of health care services for the foster child, including:

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

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

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

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

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

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

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

~~(10)~~ (11) the health records of the child including information available regarding:

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

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

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

(iv) the child's medications; and

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

~~(11)~~ (12) an independent living plan for a child age ~~16~~ 14 or older. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

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

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

(v) planning for housing;

(vi) social and recreational skills; ~~and~~

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

(viii) regular opportunities to engage in age-appropriate or developmentally appropriate activities typical for the child's age group, taking into consideration the capacities of the individual child; and

~~(12)~~ (13) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes.

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

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

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

Sec. 41. Minnesota Statutes 2014, section 260C.212, is amended by adding a subdivision to read:

Subd. 13. **Protecting missing and runaway children and youth at risk of sex trafficking.** (a) The local social services agency shall expeditiously locate any child missing from foster care.

(b) The local social services agency shall report immediately, but no later than 24 hours, after receiving information on a missing or abducted child to the local law enforcement agency for entry into the National Crime Information Center (NCIC) database of the Federal Bureau of Investigation, and to the National Center for Missing and Exploited Children.

(c) The local social services agency shall not discharge a child from foster care or close the social services case until diligent efforts have been exhausted to locate the child and the court terminates the agency's jurisdiction.

(d) The local social services agency shall determine the primary factors that contributed to the child's running away or otherwise being absent from care and, to the extent possible and appropriate, respond to those factors in current and subsequent placements.

(e) The local social services agency shall determine what the child experienced while absent from care, including screening the child to determine if the child is a possible sex trafficking victim as defined in section 609.321, subdivision 7b.

(f) The local social services agency shall report immediately, but no later than 24 hours, to the local law enforcement agency any reasonable cause to believe a child is, or is at risk of being, a sex trafficking victim.

(g) The local social services agency shall determine appropriate services as described in section 145.4717 with respect to any child for whom the local social services agency has responsibility for placement, care, or supervision when the local social services agency has reasonable cause to believe the child is, or is at risk of being, a sex trafficking victim.

Sec. 42. Minnesota Statutes 2014, section 260C.212, is amended by adding a subdivision to read:

Subd. 14. **Support normalcy for foster children.** Responsible social services agencies and child-placing agencies shall support a foster child's emotional and developmental growth by permitting the child to participate in activities or events that are generally accepted as suitable for children of the same chronological age or are developmentally appropriate for the child. Foster parents and residential facility staff are permitted to allow foster children to participate in extracurricular, social, or cultural activities that are typical for the child's age by applying reasonable and prudent parenting standards. Reasonable and prudent parenting standards are characterized by careful and sensible parenting decisions that maintain the child's health and safety, and are made in the child's best interest.

Sec. 43. Minnesota Statutes 2014, section 260C.331, subdivision 1, is amended to read:

Subdivision 1. **Care, examination, or treatment.** (a) Except where parental rights are terminated,

(1) whenever legal custody of a child is transferred by the court to a responsible social services agency,

(2) whenever legal custody is transferred to a person other than the responsible social services agency, but under the supervision of the responsible social services agency, or

(3) whenever a child is given physical or mental examinations or treatment under order of the court, and no provision is otherwise made by law for payment for the care, examination, or treatment of the child, these costs are a charge upon the welfare funds of the county in which proceedings are held upon certification of the judge of juvenile court.

(b) The court shall order, and the responsible social services agency shall require, the parents or custodian of a child, while the child is under the age of 18, to use the total income and resources attributable to the child for the period of care, examination, or treatment, except for clothing and personal needs allowance as provided in section 256B.35, to reimburse the county for the cost of care, examination, or treatment. Income and resources attributable to the child include, but are not limited to, Social Security benefits, Supplemental Security Income (SSI), veterans benefits, railroad retirement benefits and child support. When the child is over the age of 18, and continues to receive care, examination, or treatment, the court shall order, and the responsible social services agency shall require, reimbursement from the child for the cost of care, examination, or treatment from the income and resources attributable to the child less the clothing and personal needs allowance. Income does not include earnings from a child over the age of

18 who is working as part of a plan under section 260C.212, subdivision 1, paragraph (c), clause ~~(11)~~ (12), to transition from foster care, or the income and resources from sources other than Supplemental Security Income and child support that are needed to complete the requirements listed in section 260C.203.

(c) If the income and resources attributable to the child are not enough to reimburse the county for the full cost of the care, examination, or treatment, the court shall inquire into the ability of the parents to support the child and, after giving the parents a reasonable opportunity to be heard, the court shall order, and the responsible social services agency shall require, the parents to contribute to the cost of care, examination, or treatment of the child. When determining the amount to be contributed by the parents, the court shall use a fee schedule based upon ability to pay that is established by the responsible social services agency and approved by the commissioner of human services. The income of a stepparent who has not adopted a child shall be excluded in calculating the parental contribution under this section.

(d) The court shall order the amount of reimbursement attributable to the parents or custodian, or attributable to the child, or attributable to both sources, withheld under chapter 518A from the income of the parents or the custodian of the child. A parent or custodian who fails to pay without good reason may be proceeded against for contempt, or the court may inform the county attorney, who shall proceed to collect the unpaid sums, or both procedures may be used.

(e) If the court orders a physical or mental examination for a child, the examination is a medically necessary service for purposes of determining whether the service is covered by a health insurance policy, health maintenance contract, or other health coverage plan. Court-ordered treatment shall be subject to policy, contract, or plan requirements for medical necessity. Nothing in this paragraph changes or eliminates benefit limits, conditions of coverage, co-payments or deductibles, provider restrictions, or other requirements in the policy, contract, or plan that relate to coverage of other medically necessary services.

(f) Notwithstanding paragraph (b), (c), or (d), a parent, custodian, or guardian of the child is not required to use income and resources attributable to the child to reimburse the county for costs of care and is not required to contribute to the cost of care of the child during any period of time when the child is returned to the home of that parent, custodian, or guardian pursuant to a trial home visit under section 260C.201, subdivision 1, paragraph (a).

Sec. 44. Minnesota Statutes 2014, section 260C.451, subdivision 2, is amended to read:

Subd. 2. **Independent living plan.** Upon the request of any child in foster care immediately prior to the child's 18th birthday and who is in foster care at the time of the request, the responsible social services agency shall, in conjunction with the child and other appropriate parties, update the independent living plan required under section 260C.212, subdivision 1, paragraph (c), clause ~~(11)~~ (12), related to the child's employment, vocational, educational, social, or maturational needs. The agency shall provide continued services and foster care for the child including those services that are necessary to implement the independent living plan.

Sec. 45. Minnesota Statutes 2014, section 260C.451, subdivision 6, is amended to read:

Subd. 6. **Reentering foster care and accessing services after age 18.** (a) Upon request of an individual between the ages of 18 and 21 who had been under the guardianship of the commissioner and who has left foster care without being adopted, the responsible social services agency which had been the commissioner's agent for purposes of the guardianship shall develop with the individual a plan to increase the individual's ability to live safely and independently using the plan requirements of section 260C.212, subdivision 1, paragraph ~~(b)~~ (c), clause ~~(11)~~ (12), and to assist the individual to meet one or more of the eligibility criteria in subdivision 4 if the individual wants to reenter foster care. The agency shall provide foster care as required to implement the plan. The agency shall enter into a voluntary placement agreement under section 260C.229 with the individual if the plan includes foster care.

(b) Individuals who had not been under the guardianship of the commissioner of human services prior to age 18 and are between the ages of 18 and 21 may ask to reenter foster care after age 18 and, to the extent funds are available, the responsible social services agency that had responsibility for planning for the individual before discharge from foster care may provide foster care or other services to the individual for the purpose of increasing the individual's ability to live safely and independently and to meet the eligibility criteria in subdivision 3a, if the individual:

(1) was in foster care for the six consecutive months prior to the person's 18th birthday and was not discharged home, adopted, or received into a relative's home under a transfer of permanent legal and physical custody under section 260C.515, subdivision 4; or

(2) was discharged from foster care while on runaway status after age 15.

(c) In conjunction with a qualifying and eligible individual under paragraph (b) and other appropriate persons, the responsible social services agency shall develop a specific plan related to that individual's vocational, educational, social, or maturational needs and, to the extent funds are available, provide foster care as required to implement the

plan. The agency shall enter into a voluntary placement agreement with the individual if the plan includes foster care.

(d) Youth who left foster care while under guardianship of the commissioner of human services retain eligibility for foster care for placement at any time between the ages of 18 and 21.

Sec. 46. Minnesota Statutes 2014, section 260C.515, subdivision 5, is amended to read:

Subd. 5. **Permanent custody to agency.** The court may order permanent custody to the responsible social services agency for continued placement of the child in foster care but only if it approves the responsible social services agency's compelling reasons that no other permanency disposition order is in the child's best interests and:

(1) the child has reached age ~~12~~ 16 and has been asked about the child's desired permanency outcome;

(2) the child is a sibling of a child described in clause (1) and the siblings have a significant positive relationship and are ordered into the same foster home;

(3) the responsible social services agency has made reasonable efforts to locate and place the child with an adoptive family or a fit and willing relative who would either agree to adopt the child or to a transfer of permanent legal and physical custody of the child, but these efforts have not proven successful; and

(4) the parent will continue to have visitation or contact with the child and will remain involved in planning for the child.

Sec. 47. Minnesota Statutes 2014, section 260C.521, subdivision 1, is amended to read:

Subdivision 1. **Child in permanent custody of responsible social services agency.** (a) Court reviews of an order for permanent custody to the responsible social services agency for placement of the child in foster care must be conducted at least yearly at an in-court appearance hearing.

(b) The purpose of the review hearing is to ensure:

(1) the order for permanent custody to the responsible social services agency for placement of the child in foster care continues to be in the best interests of the child and that no other permanency disposition order is in the best interests of the child;

(2) that the agency is assisting the child to build connections to the child's family and community; and

(3) that the agency is appropriately planning with the child for development of independent living skills for the child and, as appropriate, for the orderly and successful

transition to independent living that may occur if the child continues in foster care without another permanency disposition order.

(c) The court must review the child's out-of-home placement plan and the reasonable efforts of the agency to finalize an alternative permanent plan for the child including the agency's efforts to:

(1) ensure that permanent custody to the agency with placement of the child in foster care continues to be the most appropriate legal arrangement for meeting the child's need for permanency and stability or, if not, to identify and attempt to finalize another permanency disposition order under this chapter that would better serve the child's needs and best interests;

(2) identify a specific foster home for the child, if one has not already been identified;

(3) support continued placement of the child in the identified home, if one has been identified;

(4) ensure appropriate services are provided to address the physical health, mental health, and educational needs of the child during the period of foster care and also ensure appropriate services or assistance to maintain relationships with appropriate family members and the child's community; and

(5) plan for the child's independence upon the child's leaving foster care living as required under section 260C.212, subdivision 1.

(d) The court may find that the agency has made reasonable efforts to finalize the permanent plan for the child when:

(1) the agency has made reasonable efforts to identify a more legally permanent home for the child than is provided by an order for permanent custody to the agency for placement in foster care; ~~and~~

(2) the child has been asked about the child's desired permanency outcome; and

~~(2)~~ (3) the agency's engagement of the child in planning for independent living is reasonable and appropriate.

Sec. 48. Minnesota Statutes 2014, section 260C.521, subdivision 2, is amended to read:

Subd. 2. **Modifying order for permanent legal and physical custody to a relative.** (a) An order for a relative to have permanent legal and physical custody of a child may be modified using standards under sections 518.18 and 518.185.

(b) If a relative named as permanent legal and physical custodian in an order made under this chapter becomes incapacitated or dies, a successor custodian named in the kinship placement agreement under section 256N.22, subdivision 2, may file a request to modify the order for permanent legal and physical custody to name the successor

custodian as the permanent legal and physical custodian of the child. The court shall modify the order to name the successor custodian as the permanent legal and physical custodian upon reviewing the background study required under section 245C.33 if the court finds the modification is in the child's best interests.

(c) The social services agency is a party to the proceeding and must receive notice.

Sec. 49. Minnesota Statutes 2014, section 260C.607, subdivision 4, is amended to read:

Subd. 4. **Content of review.** (a) The court shall review:

(1) the agency's reasonable efforts under section 260C.605 to finalize an adoption for the child as appropriate to the stage of the case; and

(2) the child's current out-of-home placement plan required under section 260C.212, subdivision 1, to ensure the child is receiving all services and supports required to meet the child's needs as they relate to the child's:

(i) placement;

(ii) visitation and contact with siblings;

(iii) visitation and contact with relatives;

(iv) medical, mental, and dental health; and

(v) education.

(b) When the child is age ~~16~~ 14 and older, and as long as the child continues in foster care, the court shall also review the agency's planning for the child's independent living after leaving foster care including how the agency is meeting the requirements of section 260C.212, subdivision 1, paragraph (c), clause ~~(11)~~ (12). The court shall use the review requirements of section 260C.203 in any review conducted under this paragraph.

Sec. 50. Minnesota Statutes 2014, section 518A.26, subdivision 14, is amended to read:

Subd. 14. **Obligor.** "Obligor" means a person obligated to pay maintenance or support. ~~A person who has primary physical custody of a child is presumed not to be an obligor for purposes of a child support order under section 518A.34, unless section 518A.36, subdivision 3, applies or the court makes specific written findings to overcome this presumption.~~ For purposes of ordering medical support under section 518A.41, a parent who has primary physical custody of a child may be an obligor subject to a payment agreement under section 518A.69.

Sec. 51. Minnesota Statutes 2014, section 518A.32, subdivision 2, is amended to read:

Subd. 2. **Methods.** Determination of potential income must be made according to one of three methods, as appropriate:

(1) the parent's probable earnings level based on employment potential, recent work history, and occupational qualifications in light of prevailing job opportunities and earnings levels in the community;

(2) if a parent is receiving unemployment compensation or workers' compensation, that parent's income may be calculated using the actual amount of the unemployment compensation or workers' compensation benefit received; or

(3) the amount of income a parent could earn working ~~full time~~ 30 hours per week at ~~150~~ 100 percent of the current federal or state minimum wage, whichever is higher.

Sec. 52. Minnesota Statutes 2014, section 518A.39, subdivision 1, is amended to read:

Subdivision 1. **Authority.** After an order under this chapter or chapter 518 for maintenance or support money, temporary or permanent, or for the appointment of trustees to receive property awarded as maintenance or support money, the court may from time to time, on motion of either of the parties, a copy of which is served on the public authority responsible for child support enforcement if payments are made through it, or on motion of the public authority responsible for support enforcement, modify the order respecting the amount of maintenance or support money or medical support, and the payment of it, and also respecting the appropriation and payment of the principal and income of property held in trust, and may make an order respecting these matters which it might have made in the original proceeding, except as herein otherwise provided. A party or the public authority also may bring a motion for contempt of court if the obligor is in arrears in support or maintenance payments.

Sec. 53. Minnesota Statutes 2014, section 518A.39, is amended by adding a subdivision to read:

Subd. 8. **Medical support-only modification.** (a) The medical support terms of a support order and determination of the child dependency tax credit may be modified without modification of the full order for support or maintenance, if the order has been established or modified in its entirety within three years from the date of the motion, and upon a showing of one or more of the following:

(1) a change in the availability of appropriate health care coverage or a substantial increase or decrease in health care coverage costs;

(2) a change in the eligibility for medical assistance under chapter 256B;

(3) a party's failure to carry court-ordered coverage, or to provide other medical support as ordered;

(4) the federal child dependency tax credit is not ordered for the same parent who is ordered to carry health care coverage; or

(5) the federal child dependency tax credit is not addressed in the order and the noncustodial parent is ordered to carry health care coverage.

(b) For a motion brought under this subdivision, a modification of the medical support terms of an order may be made retroactive only with respect to any period during which the petitioning party has pending a motion for modification, but only from the date of service of notice of the motion on the responding party and on the public authority if public assistance is being furnished or the county attorney is the attorney of record.

(c) The court need not hold an evidentiary hearing on a motion brought under this subdivision for modification of medical support only.

(d) Sections 518.14 and 518A.735 shall govern the award of attorney fees for motions brought under this subdivision.

(e) The PICS originally stated in the order being modified shall be used to determine the modified medical support order under section 518A.41 for motions brought under this subdivision.

Sec. 54. Minnesota Statutes 2014, section 518A.41, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** The definitions in this subdivision apply to this chapter and chapter 518.

(a) "Health care coverage" means medical, dental, or other health care benefits that are provided by one or more health plans. Health care coverage does not include any form of public coverage.

(b) "Health carrier" means a carrier as defined in sections 62A.011, subdivision 2, and 62L.02, subdivision 16.

(c) "Health plan" means a plan, other than any form of public coverage, that provides medical, dental, or other health care benefits and is:

(1) provided on an individual or group basis;

(2) provided by an employer or union;

(3) purchased in the private market; or

(4) available to a person eligible to carry insurance for the joint child, including a party's spouse or parent.

Health plan includes, but is not limited to, a plan meeting the definition under section 62A.011, subdivision 3, except that the exclusion of coverage designed solely to provide dental or vision care under section 62A.011, subdivision 3, clause (6), does not apply to the definition of health plan under this section; a group health plan governed under the

federal Employee Retirement Income Security Act of 1974 (ERISA); a self-insured plan under sections 43A.23 to 43A.317 and 471.617; and a policy, contract, or certificate issued by a community-integrated service network licensed under chapter 62N.

(d) "Medical support" means providing health care coverage for a joint child by carrying health care coverage for the joint child or by contributing to the cost of health care coverage, public coverage, unreimbursed medical expenses, and uninsured medical expenses of the joint child.

(e) "National medical support notice" means an administrative notice issued by the public authority to enforce health insurance provisions of a support order in accordance with Code of Federal Regulations, title 45, section 303.32, in cases where the public authority provides support enforcement services.

(f) "Public coverage" means health care benefits provided by any form of medical assistance under chapter 256B ~~or MinnesotaCare under chapter 256L~~. Public coverage does not include MinnesotaCare or federally tax-subsidized medical plans.

(g) "Uninsured medical expenses" means a joint child's reasonable and necessary health-related expenses if the joint child is not covered by a health plan or public coverage when the expenses are incurred.

(h) "Unreimbursed medical expenses" means a joint child's reasonable and necessary health-related expenses if a joint child is covered by a health plan or public coverage and the plan or coverage does not pay for the total cost of the expenses when the expenses are incurred. Unreimbursed medical expenses do not include the cost of premiums. Unreimbursed medical expenses include, but are not limited to, deductibles, co-payments, and expenses for orthodontia, and prescription eyeglasses and contact lenses, but not over-the-counter medications if coverage is under a health plan.

Sec. 55. Minnesota Statutes 2014, section 518A.41, subdivision 3, is amended to read:

Subd. 3. **Determining appropriate health care coverage.** In determining whether a parent has appropriate health care coverage for the joint child, the court must consider the following factors:

(1) comprehensiveness of health care coverage providing medical benefits. Dependent health care coverage providing medical benefits is presumed comprehensive if it includes medical and hospital coverage and provides for preventive, emergency, acute, and chronic care; or if it meets the minimum essential coverage definition in United States Code, title 26, section 5000A(f). If both parents have health care coverage providing medical benefits that is presumed comprehensive under this paragraph, the court must

determine which parent's coverage is more comprehensive by considering what other benefits are included in the coverage;

(2) accessibility. Dependent health care coverage is accessible if the covered joint child can obtain services from a health plan provider with reasonable effort by the parent with whom the joint child resides. Health care coverage is presumed accessible if:

(i) primary care is available within 30 minutes or 30 miles of the joint child's residence and specialty care is available within 60 minutes or 60 miles of the joint child's residence;

(ii) the health care coverage is available through an employer and the employee can be expected to remain employed for a reasonable amount of time; and

(iii) no preexisting conditions exist to unduly delay enrollment in health care coverage;

(3) the joint child's special medical needs, if any; and

(4) affordability. Dependent health care coverage is affordable if it is reasonable in cost. If both parents have health care coverage available for a joint child that is comparable with regard to comprehensiveness of medical benefits, accessibility, and the joint child's special needs, the least costly health care coverage is presumed to be the most appropriate health care coverage for the joint child.

Sec. 56. Minnesota Statutes 2014, section 518A.41, subdivision 4, is amended to read:

Subd. 4. **Ordering health care coverage.** (a) If a joint child is presently enrolled in health care coverage, the court must order that the parent who currently has the joint child enrolled continue that enrollment unless the parties agree otherwise or a party requests a change in coverage and the court determines that other health care coverage is more appropriate.

(b) If a joint child is not presently enrolled in health care coverage providing medical benefits, upon motion of a parent or the public authority, the court must determine whether one or both parents have appropriate health care coverage providing medical benefits for the joint child.

(c) If only one parent has appropriate health care coverage providing medical benefits available, the court must order that parent to carry the coverage for the joint child.

(d) If both parents have appropriate health care coverage providing medical benefits available, the court must order the parent with whom the joint child resides to carry the coverage for the joint child, unless:

(1) a party expresses a preference for health care coverage providing medical benefits available through the parent with whom the joint child does not reside;

(2) the parent with whom the joint child does not reside is already carrying dependent health care coverage providing medical benefits for other children and the cost of contributing to the premiums of the other parent's coverage would cause the parent with whom the joint child does not reside extreme hardship; or

(3) the parties agree as to which parent will carry health care coverage providing medical benefits and agree on the allocation of costs.

(e) If the exception in paragraph (d), clause (1) or (2), applies, the court must determine which parent has the most appropriate coverage providing medical benefits available and order that parent to carry coverage for the joint child.

(f) If neither parent has appropriate health care coverage available, the court must order the parents to:

(1) contribute toward the actual health care costs of the joint children based on a pro rata share; or

(2) if the joint child is receiving any form of public coverage, the parent with whom the joint child does not reside shall contribute a monthly amount toward the actual cost of public coverage. The amount of the noncustodial parent's contribution is determined by applying the noncustodial parent's PICS to the premium ~~schedule for public coverage~~ scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (c). If the noncustodial parent's PICS meets the eligibility requirements for ~~public coverage~~ MinnesotaCare, the contribution is the amount the noncustodial parent would pay for the child's premium. If the noncustodial parent's PICS exceeds the eligibility requirements ~~for public coverage~~, the contribution is the amount of the premium for the highest eligible income on the ~~appropriate~~ premium ~~schedule for public coverage~~ scale for MinnesotaCare under section 256L.15, subdivision 2, paragraph (c). For purposes of determining the premium amount, the noncustodial parent's household size is equal to one parent plus the child or children who are the subject of the child support order. The custodial parent's obligation is determined under the requirements for public coverage as set forth in chapter 256B ~~or 256L.~~; or

(3) if the noncustodial parent's PICS meet the eligibility requirement for public coverage under chapter 256B or the noncustodial parent receives public assistance, the noncustodial parent must not be ordered to contribute toward the cost of public coverage.

(g) If neither parent has appropriate health care coverage available, the court may order the parent with whom the child resides to apply for public coverage for the child.

(h) The commissioner of human services must publish a table with the premium schedule for public coverage and update the chart for changes to the schedule by July 1 of each year.

(i) If a joint child is not presently enrolled in health care coverage providing dental benefits, upon motion of a parent or the public authority, the court must determine whether one or both parents have appropriate dental health care coverage for the joint child, and the court may order a parent with appropriate dental health care coverage available to carry the coverage for the joint child.

(j) If a joint child is not presently enrolled in available health care coverage providing benefits other than medical benefits or dental benefits, upon motion of a parent or the public authority, the court may determine whether that other health care coverage for the joint child is appropriate, and the court may order a parent with that appropriate health care coverage available to carry the coverage for the joint child.

Sec. 57. Minnesota Statutes 2014, section 518A.41, subdivision 14, is amended to read:

Subd. 14. **Child support enforcement services.** The public authority must take necessary steps to establish ~~and enforce~~, enforce, and modify an order for medical support if the joint child receives public assistance or a party completes an application for services from the public authority under section 518A.51.

Sec. 58. Minnesota Statutes 2014, section 518A.41, subdivision 15, is amended to read:

Subd. 15. **Enforcement.** (a) Remedies available for collecting and enforcing child support apply to medical support.

(b) For the purpose of enforcement, the following are additional support:

(1) the costs of individual or group health or hospitalization coverage;

(2) dental coverage;

(3) medical costs ordered by the court to be paid by either party, including health care coverage premiums paid by the obligee because of the obligor's failure to obtain coverage as ordered; and

(4) liabilities established under this subdivision.

(c) A party who fails to carry court-ordered dependent health care coverage is liable for the joint child's uninsured medical expenses unless a court order provides otherwise. A party's failure to carry court-ordered coverage, or to provide other medical support as ordered, is a basis for modification of ~~a~~ medical support ~~order~~ under section 518A.39, subdivision ~~2~~ 8, unless it meets the presumption in section 518A.39, subdivision 2.

(d) Payments by the health carrier or employer for services rendered to the dependents that are directed to a party not owed reimbursement must be endorsed over to and forwarded to the vendor or appropriate party or the public authority. A party retaining insurance reimbursement not owed to the party is liable for the amount of the reimbursement.

Sec. 59. Minnesota Statutes 2014, section 518A.43, is amended by adding a subdivision to read:

Subd. 1a. **Income disparity between parties.** The court may deviate from the presumptive child support obligation under section 518A.34 and elect not to order a party who has between ten and 45 percent parenting time to pay basic support where such a significant disparity of income exists between the parties that an order directing payment of basic support would be detrimental to the parties' joint child.

Sec. 60. Minnesota Statutes 2014, section 518A.46, subdivision 3, is amended to read:

Subd. 3. **Contents of pleadings.** (a) In cases involving establishment or modification of a child support order, the initiating party shall include the following information, if known, in the pleadings:

(1) names, addresses, and dates of birth of the parties;

(2) Social Security numbers of the parties and the minor children of the parties, which information shall be considered private information and shall be available only to the parties, the court, and the public authority;

(3) other support obligations of the obligor;

(4) names and addresses of the parties' employers;

(5) gross income of the parties as calculated in section 518A.29;

(6) amounts and sources of any other earnings and income of the parties;

(7) health insurance coverage of parties;

(8) types and amounts of public assistance received by the parties, including Minnesota family investment plan, child care assistance, medical assistance, ~~MinnesotaCare,~~ title IV-E foster care, or other form of assistance as defined in section 256.741, subdivision 1; and

(9) any other information relevant to the computation of the child support obligation under section 518A.34.

(b) For all matters scheduled in the expedited process, whether or not initiated by the public authority, the nonattorney employee of the public authority shall file with the court and serve on the parties the following information:

(1) information pertaining to the income of the parties available to the public authority from the Department of Employment and Economic Development;

(2) a statement of the monthly amount of child support, medical support, child care, and arrears currently being charged the obligor on Minnesota IV-D cases;

(3) a statement of the types and amount of any public assistance, as defined in section 256.741, subdivision 1, received by the parties; and

(4) any other information relevant to the determination of support that is known to the public authority and that has not been otherwise provided by the parties.

The information must be filed with the court or child support magistrate at least five days before any hearing involving child support, medical support, or child care reimbursement issues.

Sec. 61. Minnesota Statutes 2014, section 518A.46, is amended by adding a subdivision to read:

Subd. 3a. **Contents of pleadings for medical support modifications.** (a) In cases involving modification of only the medical support portion of a child support order under section 518A.39, subdivision 8, the initiating party shall include the following information, if known, in the pleadings:

(1) names, addresses, and dates of birth of the parties;

(2) Social Security numbers of the parties and the minor children of the parties, which shall be considered private information and shall be available only to the parties, the court, and the public authority;

(3) a copy of the full support order being modified;

(4) names and addresses of the parties' employers;

(5) gross income of the parties as stated in the order being modified;

(6) health insurance coverage of the parties; and

(7) any other information relevant to the determination of the medical support obligation under section 518A.41.

(b) For all matters scheduled in the expedited process, whether or not initiated by the public authority, the nonattorney employee of the public authority shall file with the court and serve on the parties the following information:

(1) a statement of the monthly amount of child support, medical support, child care, and arrears currently being charged the obligor on Minnesota IV-D cases;

(2) a statement of the amount of medical assistance received by the parties; and

(3) any other information relevant to the determination of medical support that is known to the public authority and that has not been otherwise provided by the parties.

The information must be filed with the court or child support magistrate at least five days before the hearing on the motion to modify medical support.

Sec. 62. Minnesota Statutes 2014, section 518A.51, is amended to read:

518A.51 FEES FOR IV-D SERVICES.

(a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, or medical assistance~~, or MinnesotaCare~~ programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

~~(b) An application fee of $25 shall be paid by the person who applies for child support and maintenance collection services, except persons who are receiving public assistance as defined in section 256.741 and the diversionary work program under section 256J.95, persons who transfer from public assistance to nonpublic assistance status, and minor parents and parents enrolled in a public secondary school, area learning center, or alternative learning program approved by the commissioner of education.~~

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

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

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

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

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

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

~~(g)~~ (f) Federal collections fees collected under paragraph ~~(e)~~ (b) and cost recovery fees collected under paragraphs (c) and (d) ~~and (e)~~ retained by the commissioner of human services shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund account established under paragraph ~~(i)~~ (h). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

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

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

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

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

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

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

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

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

Sec. 63. Minnesota Statutes 2014, section 518A.53, subdivision 4, is amended to read:

Subd. 4. **Collection services.** (a) The commissioner of human services shall prepare and make available to the courts a notice of services that explains child support and maintenance collection services available through the public authority, including income withholding, and the fees for such services. Upon receiving a petition for dissolution of marriage or legal separation, the court administrator shall promptly send the notice of services to the petitioner and respondent at the addresses stated in the petition.

(b) Either the obligee or obligor may at any time apply to the public authority for either full IV-D services or for income withholding only services.

(c) For those persons applying for income withholding only services, a monthly service fee of $15 must be charged to the obligor. This fee is in addition to the amount of the support order and shall be withheld through income withholding. The public authority shall explain the service options in this section to the affected parties and encourage the application for full child support collection services.

(d) If the obligee is not a current recipient of public assistance as defined in section 256.741, the person who applied for services may at any time choose to terminate either full IV-D services or income withholding only services regardless of whether income withholding is currently in place. The obligee or obligor may reapply for either full IV-D services or income withholding only services at any time. ~~Unless the applicant is a recipient of public assistance as defined in section 256.741, a $25 application fee shall be charged at the time of each application.~~

(e) When a person terminates IV-D services, if an arrearage for public assistance as defined in section 256.741 exists, the public authority may continue income withholding, as well as use any other enforcement remedy for the collection of child support, until all public assistance arrears are paid in full. Income withholding shall be in an amount equal to 20 percent of the support order in effect at the time the services terminated.

Sec. 64. **[518A.685] CONSUMER REPORTING AGENCY; REPORTING ARREARS.**

(a) If a public authority determines that an obligor has not paid the current monthly support obligation plus any required arrearage payment for three months, the public authority must report this information to a consumer reporting agency.

(b) Before reporting that an obligor is in arrears for court-ordered child support, the public authority must:

(1) provide written notice to the obligor that the public authority intends to report the arrears to a consumer reporting agency; and

(2) mail the written notice to the obligor's last known mailing address at least 30 days before the public authority reports the arrears to a consumer reporting agency.

(c) The obligor may, within 21 days of receipt of the notice, do the following to prevent the public authority from reporting the arrears to a consumer reporting agency:

(1) pay the arrears in full; or

(2) request an administrative review. An administrative review is limited to issues of mistaken identity, a pending legal action involving the arrears, or an incorrect arrears balance.

(d) If the public authority has reported that an obligor is in arrears for court-ordered child support and subsequently determines that the obligor has paid the court-ordered child support arrears in full, or is paying the current monthly support obligation plus any required arrearage payment, the public authority must report to the consumer reporting agency that the obligor is currently paying child support as ordered by the court.

(e) A public authority that reports arrearage information under this section must make monthly reports to a consumer reporting agency. The monthly report must be consistent with credit reporting industry standards for child support.

(f) For purposes of this section, "consumer reporting agency" has the meaning given in section 13C.001, subdivision 4, and United States Code, title 15, section 1681a(f).

Sec. 65. Minnesota Statutes 2014, section 518C.802, is amended to read:

518C.802 CONDITIONS OF RENDITION.

(a) Before making demand that the governor of another state surrender an individual charged criminally in this state with having failed to provide for the support of an obligee, the governor of this state may require a prosecutor of this state to demonstrate that at least 60 days previously the obligee had initiated proceedings for support pursuant to this chapter or that the proceeding would be of no avail.

(b) If, under this chapter or a law substantially similar to this chapter, ~~the Uniform Reciprocal Enforcement of Support Act, or the Revised Uniform Reciprocal Enforcement of Support Act,~~ the governor of another state makes a demand that the governor of this state surrender an individual charged criminally in that state with having failed to provide for the support of a child or other individual to whom a duty of support is owed, the governor may require a prosecutor to investigate the demand and report whether a proceeding for support has been initiated or would be effective. If it appears that a proceeding would be effective but has not been initiated, the governor may delay honoring the demand for a reasonable time to permit the initiation of a proceeding.

(c) If a proceeding for support has been initiated and the individual whose rendition is demanded prevails, the governor may decline to honor the demand. If the petitioner prevails and the individual whose rendition is demanded is subject to a support order, the governor may decline to honor the demand if the individual is complying with the support order.

Sec. 66. Minnesota Statutes 2014, section 626.556, subdivision 1, as amended by Laws 2015, chapter 4, section 1, is amended to read:

Subdivision 1. **Public policy.** (a) The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through physical abuse, neglect, or sexual abuse. While it is recognized that most parents want to keep their children safe, sometimes circumstances or conditions interfere with their ability to do so. When this occurs, the health and safety of the children shall be of paramount concern. Intervention and prevention efforts shall address immediate concerns for child safety and the ongoing risk of abuse or neglect and should engage the protective capacities of families. In furtherance of this public policy, it is the intent of the legislature under this section to:

(1) protect children and promote child safety;

(2) strengthen the family;

(3) make the home, school, and community safe for children by promoting responsible child care in all settings; and

(4) provide, when necessary, a safe temporary or permanent home environment for physically or sexually abused or neglected children.

(b) In addition, it is the policy of this state to:

(1) require the reporting of neglect or physical or sexual abuse of children in the home, school, and community settings;

(2) provide for the voluntary reporting of abuse or neglect of children; ~~to require a family assessment, when appropriate, as the preferred response to reports not alleging substantial child endangerment;~~

(3) require an investigation when the report alleges sexual abuse or substantial child endangerment, as defined in subdivision 2, paragraph (c);

(4) provide a family assessment when there is no alleged substantial child endangerment; and

~~(4)~~ (5) provide protective, family support, and family preservation services when needed in appropriate cases.

Sec. 67. Minnesota Statutes 2014, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(b) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve substantial child endangerment, and for reports of maltreatment in facilities required to be licensed under chapter 245A or 245D; under sections 144.50 to 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10; or in a nonlicensed personal care provider association as defined in section 256B.0625, subdivision 19a.

(c) "Substantial child endangerment" means a person responsible for a child's care, and in the case of sexual abuse includes a person who has a significant relationship to the child as defined in section 609.341, or a person in a position of authority as defined in section 609.341, who by act or omission commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) sexual abuse as defined in paragraph (d);

(3) abandonment under section 260C.301, subdivision 2;

(4) neglect as defined in paragraph (f), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(5) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(6) manslaughter in the first or second degree under section 609.20 or 609.205;

(7) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(8) solicitation, inducement, and promotion of prostitution under section 609.322;

(9) criminal sexual conduct under sections 609.342 to 609.3451;

(10) solicitation of children to engage in sexual conduct under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(12) use of a minor in sexual performance under section 617.246; or

(13) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(e) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(f) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following ~~that are done in anger or without regard to the safety of the child~~:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(9) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(10) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(h) "Report" means any report received by the local welfare agency, police department, county sheriff, or agency responsible for assessing or investigating maltreatment pursuant to this section.

(i) "Facility" means:

(1) a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 245D;

(2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

(j) "Operator" means an operator or agency as defined in section 245A.02.

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

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(n) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (e), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (o) from the Department of Human Services.

(o) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (n), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county

attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(p) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

(q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

(r) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

Sec. 68. Minnesota Statutes 2014, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in

subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency, or agency responsible for assessing or investigating the report, ~~upon receiving a report,~~ shall immediately notify the local police department or the county sheriff orally and in writing when a report is received, including reports that are not accepted for investigation or assessment. The county sheriff and the head of every local welfare agency, agency responsible for assessing or investigating reports, and police department shall each designate a person within their agency, department, or office who is responsible for ensuring that the notification duties of this paragraph and paragraph (b) are carried out. Nothing in this subdivision shall be construed to require more than one report from any institution, facility, school, or agency.

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency or agency responsible for assessing or investigating the report~~, upon receiving a report,~~ shall immediately notify the local police department or the county sheriff orally and in writing when a report is received, including reports that are not accepted for investigation or assessment.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for

licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245D; or a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Any person mandated to report shall receive a summary of the disposition of any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

Sec. 69. Minnesota Statutes 2014, section 626.556, subdivision 6a, is amended to read:

Subd. 6a. **Failure to notify.** If a local welfare agency receives a report under subdivision ~~3~~ 10, paragraph (a) ~~or (b)~~, and fails to notify the local police department or county sheriff as required by subdivision ~~3~~ 10, paragraph (a) ~~or (b)~~, the person within the agency who is responsible for ensuring that notification is made shall be subject to disciplinary action in keeping with the agency's existing policy or collective bargaining agreement on discipline of employees. If a local police department or a county sheriff receives a report under subdivision 3, paragraph (a) or (b), and fails to notify the local welfare agency as required by subdivision 3, paragraph (a) or (b), the person within the police department or county sheriff's office who is responsible for ensuring that notification is made shall be subject to disciplinary action in keeping with the agency's existing policy or collective bargaining agreement on discipline of employees.

Sec. 70. Minnesota Statutes 2014, section 626.556, subdivision 7, as amended by Laws 2015, chapter 4, section 2, is amended to read:

Subd. 7. **Report; information provided to parent.** (a) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required under subdivision 3 to report shall be followed within 72 hours, exclusive of weekends

and holidays, by a report in writing to the appropriate police department, the county sheriff, the agency responsible for ~~assessing or~~ investigating or assessing the report, or the local welfare agency.

(b) The local welfare agency shall immediately notify local law enforcement when a report is received, including reports that are not accepted for investigation or assessment.

(c) The local welfare agency shall determine if the report is accepted for an ~~assessment or~~ investigation or assessment as soon as possible but in no event longer than 24 hours after the report is received.

~~(b)~~ (d) Any report shall be of sufficient content to identify the child, any person believed to be responsible for the abuse or neglect of the child if the person is known, the nature and extent of the abuse or neglect and the name and address of the reporter. The local welfare agency or agency responsible for assessing or investigating the report shall accept a report made under subdivision 3 notwithstanding refusal by a reporter to provide the reporter's name or address as long as the report is otherwise sufficient under this paragraph. Written reports received by a police department or the county sheriff shall be forwarded immediately to the local welfare agency or the agency responsible for assessing or investigating the report. The police department or the county sheriff may keep copies of reports received by them. Copies of written reports received by a local welfare department or the agency responsible for assessing or investigating the report shall be forwarded immediately to the local police department or the county sheriff.

~~(c)~~ (e) When requested, the agency responsible for assessing or investigating a report shall inform the reporter within ten days after the report was made, either orally or in writing, whether the report was accepted or not. If the responsible agency determines the report does not constitute a report under this section, the agency shall advise the reporter the report was screened out.

(f) A local welfare agency or agency responsible for investigating or assessing a report may use a screened-out report for making an offer of social services to the subjects of the screened-out report. A local welfare agency or agency responsible for evaluating a report alleging maltreatment of a child shall consider prior reports, including screened-out reports, to determine whether an investigation or family assessment must be conducted. A screened-out report must be maintained in accordance with subdivision 11c, paragraph (a).

~~(d)~~ (g) Notwithstanding paragraph (a), the commissioner of education must inform the parent, guardian, or legal custodian of the child who is the subject of a report of alleged maltreatment in a school facility within ten days of receiving the report, either orally or in writing, whether the commissioner is assessing or investigating the report of alleged maltreatment.

~~(e)~~ (h) Regardless of whether a report is made under this subdivision, as soon as practicable after a school receives information regarding an incident that may constitute maltreatment of a child in a school facility, the school shall inform the parent, legal guardian, or custodian of the child that an incident has occurred that may constitute maltreatment of the child, when the incident occurred, and the nature of the conduct that may constitute maltreatment.

~~(f)~~ (i) A written copy of a report maintained by personnel of agencies, other than welfare or law enforcement agencies, which are subject to chapter 13 shall be confidential. An individual subject of the report may obtain access to the original report as provided by subdivision 11.

Sec. 71. Minnesota Statutes 2014, section 626.556, is amended by adding a subdivision to read:

Subd. 7a. **Guidance for screening reports.** (a) Child protection staff, supervisors, and others involved in child protection screening shall follow the guidance provided in the child maltreatment screening guidelines issued by the commissioner of human services and, when notified by the commissioner, shall immediately implement updated procedures and protocols.

(b) In consultation with the county attorney, the county social service agency may elect to adopt a standard consistent with state law that permits the county to accept reports that are not required to be screened in under the child maltreatment screening guidelines.

Sec. 72. Minnesota Statutes 2014, section 626.556, subdivision 10, is amended to read:

Subd. 10. **Duties of local welfare agency and local law enforcement agency upon receipt of report.** (a) Upon receipt of a report, the local welfare agency shall determine whether to conduct a family assessment or an investigation as appropriate to prevent or provide a remedy for child maltreatment. The local welfare agency must notify local law enforcement when a report is received, including reports that are not accepted for investigation or assessment. The local welfare agency:

(1) shall conduct an investigation on reports involving sexual abuse or substantial child endangerment;

(2) shall begin an immediate investigation if, at any time when it is using a family assessment response, it determines that there is reason to believe that substantial child endangerment or a serious threat to the child's safety exists;

(3) may conduct a family assessment for reports that do not allege substantial child endangerment. In determining that a family assessment is appropriate, the local welfare

agency may consider issues of child safety, parental cooperation, and the need for an immediate response; and

(4) may conduct a family assessment on a report that was initially screened and assigned for an investigation. In determining that a complete investigation is not required, the local welfare agency must document the reason for terminating the investigation and notify the local law enforcement agency if the local law enforcement agency is conducting a joint investigation.

If the report alleges neglect, physical abuse, or sexual abuse by a parent, guardian, or individual functioning within the family unit as a person responsible for the child's care, or sexual abuse by a person with a significant relationship to the child when that person resides in the child's household or by a sibling, the local welfare agency shall immediately conduct a family assessment or investigation as identified in clauses (1) to (4). In conducting a family assessment or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence and offer services for purposes of preventing future child maltreatment, safeguarding and enhancing the welfare of the abused or neglected minor, and supporting and preserving family life whenever possible. If the report alleges a violation of a criminal statute involving sexual abuse, physical abuse, or neglect or endangerment, under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of its investigation. In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred. When necessary the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living. In performing any of these duties, the local welfare agency shall maintain appropriate records.

If the family assessment or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency shall conduct a chemical use assessment pursuant to Minnesota Rules, part 9530.6615.

(b) When a local agency receives a report or otherwise has information indicating that a child who is a client, as defined in section 245.91, has been the subject of physical abuse, sexual abuse, or neglect at an agency, facility, or program as defined in section 245.91, it shall, in addition to its other duties under this section, immediately inform the ombudsman established under sections 245.91 to 245.97. The commissioner of education

shall inform the ombudsman established under sections 245.91 to 245.97 of reports regarding a child defined as a client in section 245.91 that maltreatment occurred at a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10.

(c) Authority of the local welfare agency responsible for assessing or investigating the child abuse or neglect report, the agency responsible for assessing or investigating the report, and of the local law enforcement agency for investigating the alleged abuse or neglect includes, but is not limited to, authority to interview, without parental consent, the alleged victim and any other minors who currently reside with or who have resided with the alleged offender. The interview may take place at school or at any facility or other place where the alleged victim or other minors might be found or the child may be transported to, and the interview conducted at, a place appropriate for the interview of a child designated by the local welfare agency or law enforcement agency. The interview may take place outside the presence of the alleged offender or parent, legal custodian, guardian, or school official. For family assessments, it is the preferred practice to request a parent or guardian's permission to interview the child prior to conducting the child interview, unless doing so would compromise the safety assessment. Except as provided in this paragraph, the parent, legal custodian, or guardian shall be notified by the responsible local welfare or law enforcement agency no later than the conclusion of the investigation or assessment that this interview has occurred. Notwithstanding rule 32 of the Minnesota Rules of Procedure for Juvenile Courts, the juvenile court may, after hearing on an ex parte motion by the local welfare agency, order that, where reasonable cause exists, the agency withhold notification of this interview from the parent, legal custodian, or guardian. If the interview took place or is to take place on school property, the order shall specify that school officials may not disclose to the parent, legal custodian, or guardian the contents of the notification of intent to interview the child on school property, as provided under this paragraph, and any other related information regarding the interview that may be a part of the child's school record. A copy of the order shall be sent by the local welfare or law enforcement agency to the appropriate school official.

(d) When the local welfare, local law enforcement agency, or the agency responsible for assessing or investigating a report of maltreatment determines that an interview should take place on school property, written notification of intent to interview the child on school property must be received by school officials prior to the interview. The notification shall include the name of the child to be interviewed, the purpose of the interview, and a reference to the statutory authority to conduct an interview on school property. For interviews conducted by the local welfare agency, the notification shall be signed by the chair of the local social services agency or the chair's designee. The notification shall be

private data on individuals subject to the provisions of this paragraph. School officials may not disclose to the parent, legal custodian, or guardian the contents of the notification or any other related information regarding the interview until notified in writing by the local welfare or law enforcement agency that the investigation or assessment has been concluded, unless a school employee or agent is alleged to have maltreated the child. Until that time, the local welfare or law enforcement agency or the agency responsible for assessing or investigating a report of maltreatment shall be solely responsible for any disclosures regarding the nature of the assessment or investigation.

Except where the alleged offender is believed to be a school official or employee, the time and place, and manner of the interview on school premises shall be within the discretion of school officials, but the local welfare or law enforcement agency shall have the exclusive authority to determine who may attend the interview. The conditions as to time, place, and manner of the interview set by the school officials shall be reasonable and the interview shall be conducted not more than 24 hours after the receipt of the notification unless another time is considered necessary by agreement between the school officials and the local welfare or law enforcement agency. Where the school fails to comply with the provisions of this paragraph, the juvenile court may order the school to comply. Every effort must be made to reduce the disruption of the educational program of the child, other students, or school staff when an interview is conducted on school premises.

(e) Where the alleged offender or a person responsible for the care of the alleged victim or other minor prevents access to the victim or other minor by the local welfare agency, the juvenile court may order the parents, legal custodian, or guardian to produce the alleged victim or other minor for questioning by the local welfare agency or the local law enforcement agency outside the presence of the alleged offender or any person responsible for the child's care at reasonable places and times as specified by court order.

(f) Before making an order under paragraph (e), the court shall issue an order to show cause, either upon its own motion or upon a verified petition, specifying the basis for the requested interviews and fixing the time and place of the hearing. The order to show cause shall be served personally and shall be heard in the same manner as provided in other cases in the juvenile court. The court shall consider the need for appointment of a guardian ad litem to protect the best interests of the child. If appointed, the guardian ad litem shall be present at the hearing on the order to show cause.

(g) The commissioner of human services, the ombudsman for mental health and developmental disabilities, the local welfare agencies responsible for investigating reports, the commissioner of education, and the local law enforcement agencies have the right to enter facilities as defined in subdivision 2 and to inspect and copy the facility's records,

including medical records, as part of the investigation. Notwithstanding the provisions of chapter 13, they also have the right to inform the facility under investigation that they are conducting an investigation, to disclose to the facility the names of the individuals under investigation for abusing or neglecting a child, and to provide the facility with a copy of the report and the investigative findings.

(h) The local welfare agency responsible for conducting a family assessment or investigation shall collect available and relevant information to determine child safety, risk of subsequent child maltreatment, and family strengths and needs and share not public information with an Indian's tribal social services agency without violating any law of the state that may otherwise impose duties of confidentiality on the local welfare agency in order to implement the tribal state agreement. The local welfare agency or the agency responsible for investigating the report shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed. Information collected includes, when relevant, information with regard to the person reporting the alleged maltreatment, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment. The local welfare agency or the agency responsible for investigating the report may make a determination of no maltreatment early in an investigation, and close the case and retain immunity, if the collected information shows no basis for a full investigation.

Information relevant to the assessment or investigation must be asked for, and may include:

(1) the child's sex and age~~,~~; prior reports of maltreatment, including any maltreatment reports that were screened out and not accepted for assessment or investigation; information relating to developmental functioning~~,~~; credibility of the child's statement~~,~~; and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) the alleged offender's age, a record check for prior reports of maltreatment, and criminal charges and convictions. The local welfare agency or the agency responsible for assessing or investigating the report must provide the alleged offender with an opportunity to make a statement. The alleged offender may submit supporting documentation relevant to the assessment or investigation;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the

child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

Nothing in this paragraph precludes the local welfare agency, the local law enforcement agency, or the agency responsible for assessing or investigating the report from collecting other relevant information necessary to conduct the assessment or investigation. Notwithstanding sections 13.384 or 144.291 to 144.298, the local welfare agency has access to medical data and records for purposes of clause (3). Notwithstanding the data's classification in the possession of any other agency, data acquired by the local welfare agency or the agency responsible for assessing or investigating the report during the course of the assessment or investigation are private data on individuals and must be maintained in accordance with subdivision 11. Data of the commissioner of education collected or maintained during and for the purpose of an investigation of alleged maltreatment in a school are governed by this section, notwithstanding the data's classification as educational, licensing, or personnel data under chapter 13.

In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (i), the commissioner of education shall collect investigative reports and data that are relevant to a report of maltreatment and are from local law enforcement and the school facility.

(i) Upon receipt of a report, the local welfare agency shall conduct a face-to-face contact with the child reported to be maltreated and with the child's primary caregiver sufficient to complete a safety assessment and ensure the immediate safety of the child. The face-to-face contact with the child and primary caregiver shall occur immediately if substantial child endangerment is alleged and within five calendar days for all other reports. If the alleged offender was not already interviewed as the primary caregiver, the local welfare agency shall also conduct a face-to-face interview with the alleged offender in the early stages of the assessment or investigation. At the initial contact, the local child welfare agency or the agency responsible for assessing or investigating the report must inform the alleged offender of the complaints or allegations made against the individual in a manner consistent with laws protecting the rights of the person who made the report. The interview with the alleged offender may be postponed if it would jeopardize an active law enforcement investigation.

(j) When conducting an investigation, the local welfare agency shall use a question and answer interviewing format with questioning as nondirective as possible to elicit spontaneous responses. For investigations only, the following interviewing methods and procedures must be used whenever possible when collecting information:

(1) audio recordings of all interviews with witnesses and collateral sources; and

(2) in cases of alleged sexual abuse, audio-video recordings of each interview with the alleged victim and child witnesses.

(k) In conducting an assessment or investigation involving a school facility as defined in subdivision 2, paragraph (i), the commissioner of education shall collect available and relevant information and use the procedures in paragraphs (i), (k), and subdivision 3d, except that the requirement for face-to-face observation of the child and face-to-face interview of the alleged offender is to occur in the initial stages of the assessment or investigation provided that the commissioner may also base the assessment or investigation on investigative reports and data received from the school facility and local law enforcement, to the extent those investigations satisfy the requirements of paragraphs (i) and (k), and subdivision 3d.

Sec. 73. Minnesota Statutes 2014, section 626.556, subdivision 10e, is amended to read:

Subd. 10e. **Determinations.** (a) The local welfare agency shall conclude the family assessment or the investigation within 45 days of the receipt of a report. The conclusion of the assessment or investigation may be extended to permit the completion of a criminal investigation or the receipt of expert information requested within 45 days of the receipt of the report.

(b) After conducting a family assessment, the local welfare agency shall determine whether services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment.

(c) After conducting an investigation, the local welfare agency shall make two determinations: first, whether maltreatment has occurred; and second, whether child protective services are needed. No determination of maltreatment shall be made when the alleged perpetrator is a child under the age of ten.

(d) If the commissioner of education conducts an assessment or investigation, the commissioner shall determine whether maltreatment occurred and what corrective or protective action was taken by the school facility. If a determination is made that maltreatment has occurred, the commissioner shall report to the employer, the school board, and any appropriate licensing entity the determination that maltreatment occurred and what corrective or protective action was taken by the school facility. In all other cases,

the commissioner shall inform the school board or employer that a report was received, the subject of the report, the date of the initial report, the category of maltreatment alleged as defined in paragraph (f), the fact that maltreatment was not determined, and a summary of the specific reasons for the determination.

(e) When maltreatment is determined in an investigation involving a facility, the investigating agency shall also determine whether the facility or individual was responsible, or whether both the facility and the individual were responsible for the maltreatment using the mitigating factors in paragraph (i). Determinations under this subdivision must be made based on a preponderance of the evidence and are private data on individuals or nonpublic data as maintained by the commissioner of education.

(f) For the purposes of this subdivision, "maltreatment" means any of the following acts or omissions:

(1) physical abuse as defined in subdivision 2, paragraph (g);

(2) neglect as defined in subdivision 2, paragraph (f);

(3) sexual abuse as defined in subdivision 2, paragraph (d);

(4) mental injury as defined in subdivision 2, paragraph (m); or

(5) maltreatment of a child in a facility as defined in subdivision 2, paragraph (i).

(g) For the purposes of this subdivision, a determination that child protective services are needed means that the local welfare agency has documented conditions during the assessment or investigation sufficient to cause a child protection worker, as defined in section 626.559, subdivision 1, to conclude that a child is at significant risk of maltreatment if protective intervention is not provided and that the individuals responsible for the child's care have not taken or are not likely to take actions to protect the child from maltreatment or risk of maltreatment.

(h) This subdivision does not mean that maltreatment has occurred solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child, in lieu of medical care. However, if lack of medical care may result in serious danger to the child's health, the local welfare agency may ensure that necessary medical services are provided to the child.

(i) When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was

responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

The evaluation of the facility's responsibility under clause (2) must not be based on the completeness of the risk assessment or risk reduction plan required under section 245A.66, but must be based on the facility's compliance with the regulatory standards for policies and procedures, training, and supervision as cited in Minnesota Statutes and Minnesota Rules.

(j) Notwithstanding paragraph (i), when maltreatment is determined to have been committed by an individual who is also the facility license holder, both the individual and the facility must be determined responsible for the maltreatment, and both the background study disqualification standards under section 245C.15, subdivision 4, and the licensing actions under sections 245A.06 or 245A.07 apply.

~~(k) Individual counties may implement more detailed definitions or criteria that indicate which allegations to investigate, as long as a county's policies are consistent with the definitions in the statutes and rules and are approved by the county board. Each local welfare agency shall periodically inform mandated reporters under subdivision 3 who work in the county of the definitions of maltreatment in the statutes and rules and any additional definitions or criteria that have been approved by the county board.~~

Sec. 74. Minnesota Statutes 2014, section 626.556, subdivision 11c, is amended to read:

Subd. 11c. **Welfare, court services agency, and school records maintained.** Notwithstanding sections 138.163 and 138.17, records maintained or records derived from reports of abuse by local welfare agencies, agencies responsible for assessing or investigating the report, court services agencies, or schools under this section shall be destroyed as provided in paragraphs (a) to (d) by the responsible authority.

(a) For reports alleging child maltreatment that were not accepted for assessment or investigation, family assessment cases, and cases where an investigation results in no determination of maltreatment or the need for child protective services, the ~~assessment or investigation~~ records must be maintained for a period of ~~four~~ five years after the date the

report was not accepted for assessment or investigation or of the final entry in the case record. Records of reports that were not accepted must contain sufficient information to identify the subjects of the report, the nature of the alleged maltreatment, and the reasons as to why the report was not accepted. Records under this paragraph may not be used for employment, background checks, or purposes other than to assist in future screening decisions and risk and safety assessments.

(b) All records relating to reports which, upon investigation, indicate either maltreatment or a need for child protective services shall be maintained for ten years after the date of the final entry in the case record.

(c) All records regarding a report of maltreatment, including any notification of intent to interview which was received by a school under subdivision 10, paragraph (d), shall be destroyed by the school when ordered to do so by the agency conducting the assessment or investigation. The agency shall order the destruction of the notification when other records relating to the report under investigation or assessment are destroyed under this subdivision.

(d) Private or confidential data released to a court services agency under subdivision 10h must be destroyed by the court services agency when ordered to do so by the local welfare agency that released the data. The local welfare agency or agency responsible for assessing or investigating the report shall order destruction of the data when other records relating to the assessment or investigation are destroyed under this subdivision.

~~(e) For reports alleging child maltreatment that were not accepted for assessment or investigation, counties shall maintain sufficient information to identify repeat reports alleging maltreatment of the same child or children for 365 days from the date the report was screened out. The commissioner of human services shall specify to the counties the minimum information needed to accomplish this purpose. Counties shall enter this data into the state social services information system.~~

Sec. 75. Minnesota Statutes 2014, section 626.556, is amended by adding a subdivision to read:

Subd. 16. **Commissioner's duty to provide oversight; quality assurance reviews; annual summary of reviews.** (a) The commissioner shall develop a plan to perform quality assurance reviews of local welfare agency screening practices and decisions. The commissioner shall provide oversight and guidance to counties to ensure consistent application of screening guidelines, thorough and appropriate screening decisions, and correct documentation and maintenance of reports. Quality assurance reviews must begin no later than September 30, 2015.

(b) The commissioner shall produce an annual report of the summary results of the reviews. The report must only contain aggregate data and may not include any data that could be used to personally identify any subject whose data is included in the report. The report is public information and must be provided to the chairs and ranking minority members of the legislative committees having jurisdiction over child protection issues.

Sec. 76. Laws 2014, chapter 189, section 5, is amended to read:

Sec. 5. Minnesota Statutes 2012, section 518C.201, is amended to read:

518C.201 BASES FOR JURISDICTION OVER NONRESIDENT.

(a) In a proceeding to establish~~,~~ or enforce~~, or modify~~ a support order or to determine parentage of a child, a tribunal of this state may exercise personal jurisdiction over a nonresident individual or the individual's guardian or conservator if:

(1) the individual is personally served with a summons or comparable document within this state;

(2) the individual submits to the jurisdiction of this state by consent, by entering a general appearance, or by filing a responsive document having the effect of waiving any contest to personal jurisdiction;

(3) the individual resided with the child in this state;

(4) the individual resided in this state and provided prenatal expenses or support for the child;

(5) the child resides in this state as a result of the acts or directives of the individual;

(6) the individual engaged in sexual intercourse in this state and the child may have been conceived by that act of intercourse;

(7) the individual asserted parentage of a child under sections 257.51 to 257.75; or

(8) there is any other basis consistent with the constitutions of this state and the United States for the exercise of personal jurisdiction.

(b) The bases of personal jurisdiction in paragraph (a) or in any other law of this state may not be used to acquire personal jurisdiction for a tribunal of this state to modify a child support order of another state unless the requirements of section 518C.611 are met, or, in the case of a foreign support order, unless the requirements of section 518C.615 are met.

Sec. 77. Laws 2014, chapter 189, section 10, is amended to read:

Sec. 10. Minnesota Statutes 2012, section 518C.206, is amended to read:

518C.206 ~~ENFORCEMENT AND MODIFICATION OF SUPPORT ORDER BY TRIBUNAL HAVING~~ CONTINUING JURISDICTION TO ENFORCE CHILD SUPPORT ORDER.

(a) A tribunal of this state that has issued a child support order consistent with the law of this state may serve as an initiating tribunal to request a tribunal of another state to enforce:

(1) the order if the order is the controlling order and has not been modified by a tribunal of another state that assumed jurisdiction pursuant to ~~this chapter or a law substantially similar to this chapter~~ the Uniform Interstate Family Support Act; or

(2) a money judgment for arrears of support and interest on the order accrued before a determination that an order of a tribunal of another state is the controlling order.

(b) A tribunal of this state having continuing~~, exclusive~~ jurisdiction over a support order may act as a responding tribunal to enforce the order.

Sec. 78. Laws 2014, chapter 189, section 11, is amended to read:

Sec. 11. Minnesota Statutes 2012, section 518C.207, is amended to read:

518C.207 ~~RECOGNITION~~ DETERMINATION OF CONTROLLING CHILD SUPPORT ORDER.

(a) If a proceeding is brought under this chapter and only one tribunal has issued a child support order, the order of that tribunal ~~is controlling~~ controls and must be recognized.

(b) If a proceeding is brought under this chapter, and two or more child support orders have been issued by tribunals of this state, another state, or a foreign country with regard to the same obligor and child, a tribunal of this state having personal jurisdiction over both the obligor and the individual obligee shall apply the following rules and by order shall determine which order controls and must be recognized:

(1) If only one of the tribunals would have continuing, exclusive jurisdiction under this chapter, the order of that tribunal ~~is controlling~~ controls.

(2) If more than one of the tribunals would have continuing, exclusive jurisdiction under this chapter:

(i) an order issued by a tribunal in the current home state of the child controls; or

(ii) if an order has not been issued in the current home state of the child, the order most recently issued controls.

(3) If none of the tribunals would have continuing, exclusive jurisdiction under this chapter, the tribunal of this state shall issue a child support order, which controls.

(c) If two or more child support orders have been issued for the same obligor and child, upon request of a party who is an individual or that is a support enforcement agency, a tribunal of this state having personal jurisdiction over both the obligor and the obligee who is an individual shall determine which order controls under paragraph (b). The

request may be filed with a registration for enforcement or registration for modification pursuant to sections 518C.601 to 518C.616, or may be filed as a separate proceeding.

(d) A request to determine which is the controlling order must be accompanied by a copy of every child support order in effect and the applicable record of payments. The requesting party shall give notice of the request to each party whose rights may be affected by the determination.

(e) The tribunal that issued the controlling order under paragraph (a), (b), or (c) has continuing jurisdiction to the extent provided in section 518C.205, or 518C.206.

(f) A tribunal of this state which determines by order which is the controlling order under paragraph (b), clause (1) or (2), or paragraph (c), or which issues a new controlling child support order under paragraph (b), clause (3), shall state in that order:

(1) the basis upon which the tribunal made its determination;

(2) the amount of prospective support, if any; and

(3) the total amount of consolidated arrears and accrued interest, if any, under all of the orders after all payments made are credited as provided by section 518C.209.

(g) Within 30 days after issuance of the order determining which is the controlling order, the party obtaining that order shall file a certified copy of it with each tribunal that issued or registered an earlier order of child support. A party or support enforcement agency obtaining the order that fails to file a certified copy is subject to appropriate sanctions by a tribunal in which the issue of failure to file arises. The failure to file does not affect the validity or enforceability of the controlling order.

(h) An order that has been determined to be the controlling order, or a judgment for consolidated arrears of support and interest, if any, made pursuant to this section must be recognized in proceedings under this chapter.

Sec. 79. Laws 2014, chapter 189, section 16, is amended to read:

Sec. 16. Minnesota Statutes 2012, section 518C.301, is amended to read:

518C.301 PROCEEDINGS UNDER THIS CHAPTER.

(a) Except as otherwise provided in this chapter, sections 518C.301 to 518C.319 apply to all proceedings under this chapter.

~~(b) This chapter provides for the following proceedings:~~

~~(1) establishment of an order for spousal support or child support pursuant to section 518C.401;~~

~~(2) enforcement of a support order and income-withholding order of another state or a foreign country without registration pursuant to sections 518C.501 and 518C.502;~~

~~(3) registration of an order for spousal support or child support of another state or a foreign country for enforcement pursuant to sections 518C.601 to 518C.612;~~

~~(4) modification of an order for child support or spousal support issued by a tribunal of this state pursuant to sections 518C.203 to 518C.206;~~

~~(5) registration of an order for child support of another state or a foreign country for modification pursuant to sections 518C.601 to 518C.612;~~

~~(6) determination of parentage of a child pursuant to section 518C.701; and~~

~~(7) assertion of jurisdiction over nonresidents pursuant to sections 518C.201 and 518C.202.~~

~~(c)~~ (b) An individual petitioner or a support enforcement agency may commence a proceeding authorized under this chapter by filing a petition in an initiating tribunal for forwarding to a responding tribunal or by filing a petition or a comparable pleading directly in a tribunal of another state or a foreign country which has or can obtain personal jurisdiction over the respondent.

Sec. 80. Laws 2014, chapter 189, section 17, is amended to read:

Sec. 17. Minnesota Statutes 2012, section 518C.303, is amended to read:

518C.303 APPLICATION OF LAW OF THIS STATE.

Except as otherwise provided by this chapter, a responding tribunal of this state shall:

(1) apply the procedural and substantive law~~, including the rules on choice of law,~~ generally applicable to similar proceedings originating in this state and may exercise all powers and provide all remedies available in those proceedings; and

(2) determine the duty of support and the amount payable in accordance with the law and support guidelines of this state.

Sec. 81. Laws 2014, chapter 189, section 18, is amended to read:

Sec. 18. Minnesota Statutes 2012, section 518C.304, is amended to read:

518C.304 DUTIES OF INITIATING TRIBUNAL.

(a) Upon the filing of a petition authorized by this chapter, an initiating tribunal of this state shall forward the petition and its accompanying documents:

(1) to the responding tribunal or appropriate support enforcement agency in the responding state; or

(2) if the identity of the responding tribunal is unknown, to the state information agency of the responding state with a request that they be forwarded to the appropriate tribunal and that receipt be acknowledged.

(b) If requested by the responding tribunal, a tribunal of this state shall issue a certificate or other documents and make findings required by the law of the responding state. If the responding tribunal is in a foreign country, upon request the tribunal of this state shall specify the amount of support sought, convert that amount into the equivalent amount in the foreign currency under applicable official or market exchange rate as publicly reported, and provide other documents necessary to satisfy the requirements of the responding foreign tribunal.

Sec. 82. Laws 2014, chapter 189, section 19, is amended to read:

Sec. 19. Minnesota Statutes 2012, section 518C.305, is amended to read:

518C.305 DUTIES AND POWERS OF RESPONDING TRIBUNAL.

(a) When a responding tribunal of this state receives a petition or comparable pleading from an initiating tribunal or directly pursuant to section 518C.301, paragraph ~~(c)~~ (b), it shall cause the petition or pleading to be filed and notify the petitioner where and when it was filed.

(b) A responding tribunal of this state, to the extent ~~otherwise authorized by~~ not prohibited by other law, may do one or more of the following:

(1) establish or enforce a support order, modify a child support order, determine the controlling child support order, or to determine parentage of a child;

(2) order an obligor to comply with a support order, specifying the amount and the manner of compliance;

(3) order income withholding;

(4) determine the amount of any arrearages, and specify a method of payment;

(5) enforce orders by civil or criminal contempt, or both;

(6) set aside property for satisfaction of the support order;

(7) place liens and order execution on the obligor's property;

(8) order an obligor to keep the tribunal informed of the obligor's current residential address, electronic mail address, telephone number, employer, address of employment, and telephone number at the place of employment;

(9) issue a bench warrant for an obligor who has failed after proper notice to appear at a hearing ordered by the tribunal and enter the bench warrant in any local and state computer systems for criminal warrants;

(10) order the obligor to seek appropriate employment by specified methods;

(11) award reasonable attorney's fees and other fees and costs; and

(12) grant any other available remedy.

(c) A responding tribunal of this state shall include in a support order issued under this chapter, or in the documents accompanying the order, the calculations on which the support order is based.

(d) A responding tribunal of this state may not condition the payment of a support order issued under this chapter upon compliance by a party with provisions for visitation.

(e) If a responding tribunal of this state issues an order under this chapter, the tribunal shall send a copy of the order to the petitioner and the respondent and to the initiating tribunal, if any.

(f) If requested to enforce a support order, arrears, or judgment or modify a support order stated in a foreign currency, a responding tribunal of this state shall convert the amount stated in the foreign currency to the equivalent amount in dollars under the applicable official or market exchange rate as publicly reported.

Sec. 83. Laws 2014, chapter 189, section 23, is amended to read:

Sec. 23. Minnesota Statutes 2012, section 518C.310, is amended to read:

518C.310 DUTIES OF STATE INFORMATION AGENCY.

(a) The unit within the Department of Human Services that receives and disseminates incoming interstate actions under title IV-D of the Social Security Act is the State Information Agency under this chapter.

(b) The State Information Agency shall:

(1) compile and maintain a current list, including addresses, of the tribunals in this state which have jurisdiction under this chapter and any support enforcement agencies in this state and transmit a copy to the state information agency of every other state;

(2) maintain a register of names and addresses of tribunals and support enforcement agencies received from other states;

(3) forward to the appropriate tribunal in the place in this state in which the individual obligee or the obligor resides, or in which the obligor's property is believed to be located, all documents concerning a proceeding under this chapter received from another state or a foreign country; and

(4) obtain information concerning the location of the obligor and the obligor's property within this state not exempt from execution, by such means as postal verification and federal or state locator services, examination of telephone directories, requests for the obligor's address from employers, and examination of governmental records, including, to the extent not prohibited by other law, those relating to real property, vital statistics, law enforcement, taxation, motor vehicles, driver's licenses, and Social Security.

Sec. 84. Laws 2014, chapter 189, section 24, is amended to read:

Sec. 24. Minnesota Statutes 2012, section 518C.311, is amended to read:

518C.311 PLEADINGS AND ACCOMPANYING DOCUMENTS.

(a) A petitioner seeking to establish or modify a support order, determine parentage of a child, or register and modify a support order of a tribunal of another state or a foreign country, in a proceeding under this chapter must file a petition. Unless otherwise ordered under section 518C.312, the petition or accompanying documents must provide, so far as known, the name, residential address, and Social Security numbers of the obligor and the obligee or parent and alleged parent, and the name, sex, residential address, Social Security number, and date of birth of each child for whom support is sought or whose ~~parenthood~~ parentage is to be determined. Unless filed at the time of registration, the petition must be accompanied by a ~~certified~~ copy of any support order ~~in effect~~ known to have been issued by another tribunal. The petition may include any other information that may assist in locating or identifying the respondent.

(b) The petition must specify the relief sought. The petition and accompanying documents must conform substantially with the requirements imposed by the forms mandated by federal law for use in cases filed by a support enforcement agency.

Sec. 85. Laws 2014, chapter 189, section 27, is amended to read:

Sec. 27. Minnesota Statutes 2012, section 518C.314, is amended to read:

518C.314 LIMITED IMMUNITY OF PETITIONER.

(a) Participation by a petitioner in a proceeding under this chapter before a responding tribunal, whether in person, by private attorney, or through services provided by the support enforcement agency, does not confer personal jurisdiction over the petitioner in another proceeding.

(b) A petitioner is not amenable to service of civil process while physically present in this state to participate in a proceeding under this chapter.

(c) The immunity granted by this section does not extend to civil litigation based on acts unrelated to a proceeding under this chapter committed by a party while physically present in this state to participate in the proceeding.

Sec. 86. Laws 2014, chapter 189, section 28, is amended to read:

Sec. 28. Minnesota Statutes 2012, section 518C.316, is amended to read:

518C.316 SPECIAL RULES OF EVIDENCE AND PROCEDURE.

(a) The physical presence of ~~the petitioner~~ a nonresident party who is an individual in a ~~responding~~ tribunal of this state is not required for the establishment, enforcement, or modification of a support order or the rendition of a judgment determining parentage of a child.

(b) ~~A verified petition,~~ An affidavit, a document substantially complying with federally mandated forms, ~~and~~ or a document incorporated by reference in any of them, not excluded under the hearsay rule if given in person, is admissible in evidence if given under ~~oath~~ penalty of perjury by a party or witness residing outside this state.

(c) A copy of the record of child support payments certified as a true copy of the original by the custodian of the record may be forwarded to a responding tribunal. The copy is evidence of facts asserted in it, and is admissible to show whether payments were made.

(d) Copies of bills for testing for parentage of a child, and for prenatal and postnatal health care of the mother and child, furnished to the adverse party at least ten days before trial, are admissible in evidence to prove the amount of the charges billed and that the charges were reasonable, necessary, and customary.

(e) Documentary evidence transmitted from outside this state to a tribunal of this state by telephone, telecopier, or other electronic means that do not provide an original record may not be excluded from evidence on an objection based on the means of transmission.

(f) In a proceeding under this chapter, a tribunal of this state shall permit a party or witness residing outside this state to be deposed or to testify under penalty of perjury by telephone, audiovisual means, or other electronic means at a designated tribunal or other location. A tribunal of this state shall cooperate with other tribunals in designating an appropriate location for the deposition or testimony.

(g) If a party called to testify at a civil hearing refuses to answer on the ground that the testimony may be self-incriminating, the trier of fact may draw an adverse inference from the refusal.

(h) A privilege against disclosure of communications between spouses does not apply in a proceeding under this chapter.

(i) The defense of immunity based on the relationship of husband and wife or parent and child does not apply in a proceeding under this chapter.

(j) A voluntary acknowledgment of paternity, certified as a true copy, is admissible to establish parentage of a child.

Sec. 87. Laws 2014, chapter 189, section 29, is amended to read:

Sec. 29. Minnesota Statutes 2012, section 518C.317, is amended to read:

518C.317 COMMUNICATIONS BETWEEN TRIBUNALS.

A tribunal of this state may communicate with a tribunal outside this state in ~~writing, by e-mail, or~~ a record, or by telephone, electronic mail, or other means, to obtain information concerning the laws of that state, the legal effect of a judgment, decree, or order of that tribunal, and the status of a proceeding. A tribunal of this state may furnish similar information by similar means to a tribunal outside this state.

Sec. 88. Laws 2014, chapter 189, section 31, is amended to read:

Sec. 31. Minnesota Statutes 2012, section 518C.319, is amended to read:

518C.319 RECEIPT AND DISBURSEMENT OF PAYMENTS.

(a) A support enforcement agency or tribunal of this state shall disburse promptly any amounts received pursuant to a support order, as directed by the order. The agency or tribunal shall furnish to a requesting party or tribunal of another state or a foreign country a certified statement by the custodian of the record of the amounts and dates of all payments received.

(b) If neither the obligor, ~~not~~ nor the obligee who is an individual, nor the child resides in this state, upon request from the support enforcement agency of this state or another state, the support enforcement agency of this state or a tribunal of this state shall:

(1) direct that the support payment be made to the support enforcement agency in the state in which the obligee is receiving services; and

(2) issue and send to the obligor's employer a conforming income-withholding order or an administrative notice of change of payee, reflecting the redirected payments.

(c) The support enforcement agency of this state receiving redirected payments from another state pursuant to a law similar to paragraph (b) shall furnish to a requesting party or tribunal of the other state a certified statement by the custodian of the record of the amount and dates of all payments received.

Sec. 89. Laws 2014, chapter 189, section 43, is amended to read:

Sec. 43. Minnesota Statutes 2012, section 518C.604, is amended to read:

518C.604 CHOICE OF LAW.

(a) Except as otherwise provided in paragraph (d), the law of the issuing state or foreign country governs:

(1) the nature, extent, amount, and duration of current payments under a registered support order;

(2) the computation and payment of arrearages and accrual of interest on the arrearages under the support order; and

(3) the existence and satisfaction of other obligations under the support order.

(b) In a proceeding for arrearages under a registered support order, the statute of limitation under the laws of this state or of the issuing state or foreign country, whichever is longer, applies.

(c) A responding tribunal of this state shall apply the procedures and remedies of this state to enforce current support and collect arrears and interest due on a support order of another state or a foreign country registered in this state.

(d) After a tribunal of this state or another state determines which is the controlling order and issues an order consolidating arrears, if any, a tribunal of this state shall prospectively apply the law of the state or foreign country issuing the controlling order, including its law on interest on arrears, on current and future support, and on consolidated arrears.

Sec. 90. Laws 2014, chapter 189, section 50, is amended to read:

Sec. 50. Minnesota Statutes 2012, section 518C.611, is amended to read:

518C.611 MODIFICATION OF CHILD SUPPORT ORDER OF ANOTHER STATE.

(a) If section 518C.613 does not apply, upon petition a tribunal of this state may modify a child support order issued in another state that is registered in this state if, after notice and hearing, it finds that:

(1) the following requirements are met:

(i) neither the child, nor the obligee who is an individual, nor the obligor resides in the issuing state;

(ii) a petitioner who is a nonresident of this state seeks modification; and

(iii) the respondent is subject to the personal jurisdiction of the tribunal of this state; or

(2) this state is the residence of the child, or a party who is an individual is subject to the personal jurisdiction of the tribunal of this state and all of the parties who are individuals have filed ~~written~~ consents in a record in the issuing tribunal for a tribunal of this state to modify the support order and assume continuing, exclusive jurisdiction ~~over the order~~.

(b) Modification of a registered child support order is subject to the same requirements, procedures, and defenses that apply to the modification of an order issued by a tribunal of this state and the order may be enforced and satisfied in the same manner.

(c) A tribunal of this state may not modify any aspect of a child support order that may not be modified under the law of the issuing state, including the duration of the obligation of support. If two or more tribunals have issued child support orders for the same obligor and child, the order that controls and must be recognized under section 518C.207 establishes the aspects of the support order which are nonmodifiable.

(d) In a proceeding to modify a child support order, the law of the state that is determined to have issued the initial controlling order governs the duration of the obligation of support. The obligor's fulfillment of the duty of support established by that order precludes imposition of a further obligation of support by a tribunal of this state.

(e) On issuance of an order by a tribunal of this state modifying a child support order issued in another state, a tribunal of this state becomes the tribunal having continuing, exclusive jurisdiction.

(f) Notwithstanding paragraphs (a) to ~~(d)~~ (e) and section 518C.201, paragraph (b), a tribunal of this state retains jurisdiction to modify an order issued by a tribunal of this state if:

(1) one party resides in another state; and

(2) the other party resides outside the United States.

Sec. 91. Laws 2014, chapter 189, section 51, is amended to read:

Sec. 51. Minnesota Statutes 2012, section 518C.612, is amended to read:

518C.612 RECOGNITION OF ORDER MODIFIED IN ANOTHER STATE.

If a child support order issued by a tribunal of this state is modified by a tribunal of another state which assumed jurisdiction ~~according to this chapter or a law substantially similar to this chapter~~ pursuant to the Uniform Interstate Family Support Act, a tribunal of this state:

(1) may enforce its order that was modified only as to arrears and interest accruing before the modification;

(2) may provide appropriate relief for violations of its order which occurred before the effective date of the modification; and

(3) shall recognize the modifying order of the other state, upon registration, for the purpose of enforcement.

Sec. 92. Laws 2014, chapter 189, section 73, is amended to read:

Sec. 73. **EFFECTIVE DATE.**

This act ~~becomes~~ is effective ~~on the date that the United States deposits the instrument of ratification for the Hague Convention on the International Recovery of Child Support and Other Forms of Family Maintenance with the Hague Conference on Private International Law~~ July 1, 2015.

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 93. **CHILD SUPPORT WORK GROUP.**

(a) A child support work group is established to review the parenting expense adjustment in Minnesota Statutes, section 518A.36, and to identify and recommend changes to the parenting expense adjustment.

(b) Members of the work group shall include:

(1) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(2) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(3) the commissioner of human services or a designee;

(4) one staff member from the Child Support Division of the Department of Human Services, appointed by the commissioner;

(5) one representative of the Minnesota State Bar Association, Family Law section, appointed by the section;

(6) one representative of the Minnesota County Attorney's Association, appointed by the association;

(7) one representative of the Minnesota Legal Services Coalition, appointed by the coalition;

(8) one representative of the Minnesota Family Support and Recovery Council, appointed by the council; and

(9) two representatives from parent advocacy groups, one representing custodial parents and one representing noncustodial parents, appointed by the commissioner of human services.

The commissioner, or the commissioner's designee, shall appoint the work group chair.

(c) The work group shall be authorized to retain the services of an economist to help create an equitable parenting expense adjustment formula. The work group may hire an economist by use of a sole-source contract.

(d) The work group shall issue a report to the chairs and ranking minority members of the legislative committees with jurisdiction over civil law, judiciary, and health and human services by January 15, 2016. The report must include recommendations for changes to the computation of child support and recommendations on the composition of a permanent child support task force.

(e) Terms, compensation, and removal of members and the filling of vacancies are governed by Minnesota Statutes, section 15.059.

(f) The work group expires January 16, 2016.

Sec. 94. **INSTRUCTIONS TO COMMISSIONER; SCREENING GUIDELINES.**

(a) No later than August 1, 2015, the commissioner of human services shall update the child maltreatment screening guidelines to require agencies to consider prior screened-out reports when determining whether a new report will be screened out or will be accepted for investigation or assessment. The updated guidelines must emphasize that intervention and prevention efforts are to focus on child safety and the ongoing risk of child abuse or neglect and that the health and safety of children are of paramount concern. The commissioner must consult with county attorneys while developing the updated guidelines.

(b) No later than September 30, 2015, the commissioner shall publish and distribute the updated guidelines and ensure that all agency staff have received training on the updated guidelines.

(c) Agency staff must implement the guidelines on October 1, 2015.

Sec. 95. **INSTRUCTIONS TO THE COMMISSIONER; CHILD MALTREATMENT SCREENING GUIDELINES.**

(a) No later than August 1, 2015, the commissioner of human services shall update the child maltreatment screening guidelines to require agencies to consider prior reports that were not screened in when determining whether a new report will or will not be screened in. The updated guidelines must emphasize that intervention and prevention efforts are to focus on child safety and the ongoing risk of child abuse or neglect, and that the health and safety of children are of paramount concern. The commissioner shall work with a diverse group of community representatives who are experts on limiting cultural and ethnic bias when developing the updated guidelines. The guidelines must be developed with special sensitivity to reducing system bias with regard to screening and assessment tools.

(b) No later than September 30, 2015, the commissioner shall publish and distribute the updated guidelines and ensure that all agency staff have received training on the updated guidelines.

(c) Agency staff must implement the guidelines by October 1, 2015.

Sec. 96. **COMMISSIONER'S DUTY TO PROVIDE TRAINING TO CHILD PROTECTION SUPERVISORS.**

The commissioner shall establish requirements for competency-based initial training, support, and continuing education for child protection supervisors. This includes developing a set of competencies specific to child protection supervisor knowledge, skills, and attitudes based on the Minnesota Child Welfare Practice Model. Competency-based training of supervisors must advance continuous emphasis and improvement in skills that

promote the use of the client's culture as a resource and the ability to integrate the client's traditions, customs, values, and faith into service delivery.

Sec. 97. **CHILD PROTECTION UPDATED FORMULA.**

The commissioner of human services shall evaluate the formulas in Minnesota Statutes, section 256M.41, and recommend an updated equitable distribution formula beginning in fiscal year 2018, for funding child protection staffing and expanded services to counties and tribes, taking into consideration any relief to counties and tribes for child welfare and foster care costs, additional tribes delivering social services, and any other relevant information that should be considered in developing a new distribution formula. The commissioner shall report to the legislative committees having jurisdiction over child protection issues by December 15, 2016.

Sec. 98. **LEGISLATIVE TASK FORCE; CHILD PROTECTION.**

(a) A legislative task force is created to:

(1) review the efforts being made to implement the recommendations of the Governor's Task Force on the Protection of Children;

(2) expand the efforts into related areas of the child welfare system;

(3) work with the commissioner and community partners to establish and evaluate child protection grants to address disparities in child welfare pursuant to Minnesota Statutes, section 256E.28; and

(4) identify additional areas within the child welfare system that need to be addressed by the legislature.

(b) The four legislative members of the governor's task force shall be the members of the legislative task force. They may appoint up to eight legislators as ex officio members of the task force.

(c) The task force may provide oversight and monitoring of:

(1) the efforts by the Department of Human Services, counties, and tribes to implement laws related to child protection;

(2) efforts by the Department of Human Services, counties, and tribes to implement the recommendations of the Governor's Task Force on the Protection of Children;

(3) efforts by agencies, including but not limited to the Minnesota Department of Education, the Minnesota Housing Finance Agency, the Minnesota Department of Corrections, and the Minnesota Department of Public Safety, to work with the Department of Human Services to assure safety and well-being for children at risk of harm or children in the child welfare system;

(4) efforts by the Department of Human Services, other agencies, counties, and tribes to implement best practices to ensure every child is protected from maltreatment and neglect and to ensure every child has the opportunity for healthy development.

(d) The task force, in cooperation with the commissioner of human services, shall issue a report to the legislature and governor February 1, 2016, and February 1, 2017. The report must contain information on the progress toward implementation of changes to the child protection system; recommendations for additional legislative changes and procedures affecting child protection and child welfare; and funding needs to implement recommended changes.

(e) The task force shall convene upon enactment of this act and shall continue until the last day of the 2017 legislative session.

ARTICLE 8

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2014, section 13.46, subdivision 2, is amended to read:

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

(1) according to section 13.05;

(2) according to court order;

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

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

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

(6) to administer federal funds or programs;

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

(8) to the Department of Revenue to assess parental contribution amounts for purposes of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's

names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

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

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

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

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

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

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

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

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

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

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

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

(i) the participant:

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

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

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

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

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

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

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

(i) the member:

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

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

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

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

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

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

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

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

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

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

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

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

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

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

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

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

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

(31) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293, if the patient has provided annual consent, consistent with section 144.293, subdivisions 2 and 4.

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

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

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

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

Sec. 2. Minnesota Statutes 2014, section 13.46, subdivision 7, is amended to read:

Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision; ~~or~~

(4) to personnel of the welfare system working in the same program or providing services to the same individual or family to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293, if the patient has provided annual consent, consistent with section 144.293, subdivisions 2 and 4;

(5) to a health care provider governed by sections 144.291 to 144.298, to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293, if the patient has provided annual consent, consistent with section 144.293, subdivisions 2 and 4; or

(6) with the consent of the client or patient.

(b) An agency of the welfare system may not require an individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding section 245.69, subdivision 2, paragraph (f), or any other law to the contrary, the responsible authority for a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in an emergency interaction with the law enforcement agency; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to respond to the emergency. Disclosure under this paragraph may include, but is not limited to, the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the client or patient. A law enforcement agency that obtains mental health data under this paragraph shall

maintain a record of the requestor, the provider of the information, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (4), a community mental health center, county mental health division, or provider must release mental health data to Criminal Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order or any other means allowed by law.

Sec. 3. Minnesota Statutes 2014, section 62Q.55, subdivision 3, is amended to read:

Subd. 3. **Emergency services.** As used in this section, "emergency services" means, with respect to an emergency medical condition:

(1) a medical screening examination, as required under section 1867 of the Social Security Act, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; ~~and~~

(2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient; and

(3) emergency services as defined in sections 245.462, subdivision 11, and 245.4871, subdivision 14.

Sec. 4. Minnesota Statutes 2014, section 144.293, subdivision 5, is amended to read:

Subd. 5. **Exceptions to consent requirement.** This section does not prohibit the release of health records:

(1) for a medical emergency when the provider is unable to obtain the patient's consent due to the patient's condition or the nature of the medical emergency;

(2) to other providers within related health care entities when necessary for the current treatment of the patient; ~~or~~

(3) to a health care facility licensed by this chapter, chapter 144A, or to the same types of health care facilities licensed by this chapter and chapter 144A that are licensed in another state when a patient:

(i) is returning to the health care facility and unable to provide consent; or

(ii) who resides in the health care facility, has services provided by an outside resource under Code of Federal Regulations, title 42, section 483.75(h), and is unable to provide consent~~.~~; or

(4) to a program in the welfare system, as defined in section 13.46, upon written documentation that access to the data is necessary to coordinate services for an individual who is receiving services from the welfare system.

Sec. 5. Minnesota Statutes 2014, section 145.56, subdivision 2, is amended to read:

Subd. 2. **Community-based programs.** To the extent funds are appropriated for the purposes of this subdivision, the commissioner shall establish a grant program to fund:

(1) community-based programs to provide education, outreach, and advocacy services to populations who may be at risk for suicide;

(2) community-based programs that educate community helpers and gatekeepers, such as family members, spiritual leaders, coaches, and business owners, employers, and coworkers on how to prevent suicide by encouraging help-seeking behaviors;

(3) community-based programs that educate populations at risk for suicide and community helpers and gatekeepers that must include information on the symptoms of depression and other psychiatric illnesses, the warning signs of suicide, skills for preventing suicides, and making or seeking effective referrals to intervention and community resources; ~~and~~

(4) community-based programs to provide evidence-based suicide prevention and intervention education to school staff, parents, and students in grades kindergarten through 12, and for students attending Minnesota colleges and universities;

(5) community-based programs to provide evidence-based suicide prevention and intervention to public school nurses, teachers, administrators, coaches, school social

workers, peace officers, firefighters, emergency medical technicians, advanced emergency medical technicians, paramedics, primary care providers, and others; and

(6) community-based, evidence-based postvention training to mental health professionals and practitioners in order to provide technical assistance to communities after a suicide and to prevent suicide clusters and contagion.

Sec. 6. Minnesota Statutes 2014, section 145.56, subdivision 4, is amended to read:

Subd. 4. **Collection and reporting suicide data.** (a) The commissioner shall coordinate with federal, regional, local, and other state agencies to collect, analyze, and annually issue a public report on Minnesota-specific data on suicide and suicidal behaviors.

(b) The commissioner, in consultation with stakeholders, shall submit a detailed plan identifying proposed methods to improve the timeliness, usefulness, and quality of suicide-related data so that the data can help identify the scope of the suicide problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs. The report shall include how to improve external cause of injury coding, progress on implementing the Minnesota Violent Death Reporting System, how to obtain and release data in a timely manner, and how to support the use of psychological autopsies.

(c) The written report must be provided to the chairs and ranking minority members of the house of representatives and senate finance and policy divisions and committees with jurisdiction over health and human services by February 1, 2016.

Sec. 7. Minnesota Statutes 2014, section 245.467, subdivision 6, is amended to read:

Subd. 6. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of persons receiving mental health services are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; ~~and~~

(2) staff who provide treatment services or case management and their clinical supervisors~~.~~; and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 4 and 5, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 4 and 5, results in civil or criminal liability under the standards in section 13.08 or 13.09.

Only persons acting consistent with section 13.05 may enter, update, or access mental health data on individuals submitted under subdivisions 4 and 5. The ability of authorized persons to enter, update, or access data must be limited through the use of role-based access that corresponds to the official duties or training level of the person, and the statutory authorization that grants access for that purpose. For data submitted under subdivisions 4 and 5 and stored in an information system not operated by a state agency, all queries and all actions in which records are viewed, accessed, accepted, or exited must be recorded in a data audit trail. Data contained in the audit trail are public data, to the extent that the data are not otherwise classified by law. The authorization of any person determined to have willfully entered, updated, accessed, shared, or disseminated data in violation of this section, or any other provision of law, must be immediately revoked and investigated. If a person is determined to have willfully gained access to data without explicit authorization, the person is subject to civil and criminal liability under sections 13.08 and 13.09.

Sec. 8. Minnesota Statutes 2014, section 245.4876, subdivision 7, is amended to read:

Subd. 7. **Restricted access to data.** The county board shall establish procedures to ensure that the names and addresses of children receiving mental health services and their families are disclosed only to:

(1) county employees who are specifically responsible for determining county of financial responsibility or making payments to providers; ~~and~~

(2) staff who provide treatment services or case management and their clinical supervisors~~.~~; and

(3) personnel of the welfare system or health care providers who have access to the data under section 13.46, subdivision 7.

Release of mental health data on individuals submitted under subdivisions 5 and 6, to persons other than those specified in this subdivision, or use of this data for purposes other than those stated in subdivisions 5 and 6, results in civil or criminal liability under section 13.08 or 13.09.

Only persons acting consistent with section 13.05 may enter, update, or access mental health data on individuals submitted under subdivisions 5 and 6. The ability of authorized persons to enter, update, or access data must be limited through the use of role-based access that corresponds to the official duties or training level of the person, and the statutory authorization that grants access for that purpose. For data submitted under subdivisions 5 and 6 and stored in an information system not operated by a state agency, all queries and all actions in which records are viewed, accessed, accepted, or exited must be recorded in a data audit trail. Data contained in the audit trail are public data, to the extent that the

data are not otherwise classified by law. The authorization of any person determined to have willfully entered, updated, accessed, shared, or disseminated data in violation of this section, or any other provision of law, must be immediately revoked and investigated. If a person is determined to have willfully gained access to data without explicit authorization, the person is subject to civil and criminal liability under sections 13.08 and 13.09.

Sec. 9. **[245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner may develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner may develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 3.

Subd. 3. **Reform projects.** (a) The commissioner may establish standards for state certification of a clinic as a certified community behavioral health clinic, in accordance with the criteria published on or before September 1, 2015, by the United States Department of Health and Human Services. Certification standards established by the commissioner shall require that:

(1) clinic staff have backgrounds in diverse disciplines, include licensed mental health professionals, and are culturally and linguistically trained to serve the needs of the clinic's patient population;

(2) clinic services are available and accessible and crisis management services are available 24 hours per day;

(3) fees for clinic services are established using a sliding fee scale and services to patients are not denied or limited due to a patient's inability to pay for services;

(4) clinics provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, community-based mental health providers, and other community services, supports, and providers including schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health Services clinics, tribally licensed health care and mental health facilities, urban Indian

health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics; and

(5) services provided by clinics include crisis mental health services, emergency crisis intervention services, and stabilization services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; patient-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for mental health services delivered by certified community behavioral health clinics, in accordance with guidance issued on or before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments shall comply with federal requirements for a 90 percent enhanced federal medical assistance percentage.

Subd. 4. **Public participation.** In developing the projects under subdivision 3, the commissioner shall consult with mental health providers, advocacy organizations, licensed mental health professionals, and Minnesota health care program enrollees who receive mental health services and their families.

Subd. 5. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with federal requirements.

Sec. 10. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 45a. **Psychiatric residential treatment facility services for persons under 21 years of age.** (a) Medical assistance covers psychiatric residential treatment facility services for persons under 21 years of age. Individuals who reach age 21 at the time they are receiving services are eligible to continue receiving services until they no longer require services or until they reach age 22, whichever occurs first.

(b) For purposes of this subdivision, "psychiatric residential treatment facility" means a facility other than a hospital that provides psychiatric services, as described in Code of Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in an inpatient setting.

(c) The commissioner shall develop admissions and discharge procedures and establish rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall enroll up to 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select psychiatric residential treatment facility services providers through a request for proposals process. Providers of state-operated services may respond to the request for proposals.

EFFECTIVE DATE. This section is effective July 1, 2016, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. **[256B.7631] CHEMICAL DEPENDENCY PROVIDER RATE INCREASE.**

For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2015, payment rates shall be increased by 2.5 percent over the rates in effect on January 1, 2014, for vendors who meet the requirements of section 254B.05.

Sec. 12. **REPORT TO LEGISLATURE; PERFORMANCE MEASURES FOR CHEMICAL DEPENDENCY TREATMENT SERVICES.**

The commissioner of human services, in consultation with members of the Minnesota State Substance Abuse Strategy and representatives of counties, tribes, health plan companies, and chemical dependency treatment providers, shall develop performance measures to assess the outcomes of chemical dependency treatment services. The commissioner shall report these performance measures to the members of the health and human services policy and finance committees in the house of representatives and senate on or before January 15, 2016.

Sec. 13. **RATE-SETTING METHODOLOGY FOR COMMUNITY-BASED MENTAL HEALTH SERVICES.**

The commissioner of human services shall conduct a comprehensive analysis of the current rate-setting methodology for all community-based mental health services for children and adults. The report shall also include recommendations for establishing pay-for-performance measures for providers delivering services consistent with evidence-based practices. In developing the report, the commissioner shall consult with stakeholders and with outside experts in Medicaid financing. The commissioner shall

provide a report on the analysis to the chairs of the legislative committees with jurisdiction over health and human services finance by January 1, 2017.

Sec. 14. **EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

By January 15, 2016, the commissioner of human services shall report to the legislative committees in the house of representatives and senate with jurisdiction over human services issues on the progress of the Excellence in Mental Health demonstration project under Minnesota Statutes, section 245.735. The commissioner shall include in the report any recommendations for legislative changes needed to implement the reform projects specified in Minnesota Statutes, section 245.735, subdivision 3.

Sec. 15. **CLUBHOUSE PROGRAM SERVICES.**

The commissioner of human services, in consultation with stakeholders, may develop service standards and a payment methodology for Clubhouse program services to be covered under medical assistance when provided by a Clubhouse International accredited provider or a provider meeting equivalent standards. The commissioner may seek federal approval for the service standards and payment methodology. Upon federal approval, the commissioner must seek and obtain legislative approval of the services standards and funding methodology allowing medical assistance coverage of the service.

Sec. 16. **SPECIAL PROJECTS; INTENSIVE TREATMENT AND SUPPORTS.**

(a) The commissioner shall fund special projects to:

(1) provide intensive treatment and supports to adolescents and young adults 26 years of age and younger who are experiencing their first psychotic or manic episode; and

(2) conduct outreach, training, and guidance, in the project's region, to mental health and health care professionals, including postsecondary health clinics, on early psychosis symptoms, screening tools, and best practices.

(b) Intensive treatment and supports includes medication management, psychoeducation for the individual and family, care coordination, employment supports, education supports, cognitive behavioral approaches, cognitive remediation, social skills training, peer support, crisis planning, and stress management.

Sec. 17. **INSTRUCTIONS TO THE COMMISSIONER.**

The commissioner of human services shall, in consultation with stakeholders, develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement.

Sec. 18. **MENTAL HEALTH CRISIS SERVICES.**

The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) develop a central phone number where calls can be routed to the appropriate crisis services;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards for crisis services; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

Sec. 19. **COMPREHENSIVE MENTAL HEALTH CENTER.**

(a) To the extent funds are appropriated for the purposes of this section, the commissioner of human services shall establish a grant for Beltrami County to fund the planning and development of a comprehensive mental health center for individuals who are under arrest or subject to arrest, individuals who are experiencing a mental health crisis, or individuals who are under a transport hold under Minnesota Statutes, section 253B.05, subdivision 2, in Beltrami County and northwestern Minnesota. The program must be a sustainable, integrated care model for the provision of mental health and substance use disorder treatment for the population served in collaboration with existing services. The model may include mobile crisis services, crisis residential services, outpatient services, and community-based services. The model must be patient-centered, culturally competent, and based on evidence-based practices.

(b) The program shall maintain data on the extent to which the center reduces incarceration and hospitalization rates for individuals with mental illness or co-occurring disorders, and the extent to which the center impacts service utilization for these individuals. In order to have the capacity to be replicated in other areas of the state, the center must report outcomes to the commissioner, at a time and in a manner determined by the commissioner. The commissioner shall use the data to evaluate the effect the program has on incarceration rates and services utilization, and report to the chairs and ranking minority members of the senate and house of representatives committees having jurisdiction over health and human services and corrections issues every two years, beginning February 1, 2017.

(c) The commissioner shall encourage the commissioners of the Minnesota Housing Finance Agency, corrections, and health to provide technical assistance and support to this program. The commissioner, together with the commissioner of health, shall determine the most appropriate model for licensure of the proposed services and which agency will regulate the services of the center. The commissioners of the Minnesota Housing Finance Agency and human services shall work with the center to provide short-term and long-term housing for individuals served by the center within the limits of existing appropriations available for low-income housing or homelessness.

Sec. 20. **REPORT ON INTENSIVE COMMUNITY REHABILITATION SERVICES.**

(a) The commissioner of human services shall issue a report to the chairs and ranking minority members of the house and senate committees with jurisdiction over health and human services programs that contains recommendations on the intensive community rehabilitation services program, including options for sustainable funding models. The report shall:

(1) analyze how the intensive community rehabilitation services program provides needed mental health services and supports that are not currently covered by medical assistance;

(2) identify similar program models that are used in other states to fill similar service gaps and the program funding sources used by those states;

(3) analyze how the intensive community rehabilitation services model differs between rural and metro areas;

(4) make recommendations for expanding services; and

(5) analyze potential sources for sustainable funding, including inclusion as a medical assistance benefit.

(b) The commissioner shall include stakeholders in developing recommendations and developing the legislative report. The commissioner shall submit the report no later than January 15, 2016.

Sec. 21. **COMMISSIONER'S DUTIES RELATED TO PEER SPECIALIST TRAINING AND OUTREACH.**

The commissioner shall collaborate with the Minnesota State Colleges and Universities system to identify coursework to fulfill the peer specialist training requirements. In addition, the commissioner shall provide outreach to community mental health providers to increase their knowledge on how peer specialists can be utilized, best practices on hiring peer specialists, how peer specialist activities can be billed, and the benefits of hiring peer specialists.

Sec. 22. **INSTRUCTIONS TO THE COMMISSIONER.**

The commissioner shall determine the number of individuals who were determined to be ineligible to receive community first services and supports because they did not require constant supervision and cuing in order to accomplish activities of daily living. The commissioner shall issue a report with these findings to the chairs and ranking minority members of the house and senate committees with jurisdiction over human services programs.

ARTICLE 9

DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2014, section 43A.241, is amended to read:

43A.241 INSURANCE CONTRIBUTIONS; FORMER ~~CORRECTIONS~~ EMPLOYEES.

(a) This section applies to a person who:

(1) was employed by the commissioner of the Department of Corrections ~~at a state institution under control of the commissioner, and in that employment was a member of the general plan of the Minnesota State Retirement System;~~ or by the Department of Human Services;

(2) was covered by the correctional employee retirement plan under section 352.91 or the general state employees retirement plan of the Minnesota State Retirement System as defined in section 352.021;

(3) while employed under clause (1), was assaulted by ~~an inmate at a state institution under control of the commissioner of the Department of Corrections; and~~:

(i) a person under correctional supervision for a criminal offense; or

(ii) a client or patient at the Minnesota sex offender program or at a state-operated forensic services program as defined in section 352.91, subdivision 3j, under the control of the commissioner of the Department of Human Services; and

~~(3)~~ (4) as a direct result of the assault under clause (3), was determined to be totally and permanently disabled under laws governing the Minnesota State Retirement System.

(b) For a person to whom this section applies, the commissioner of the Department of Corrections or the commissioner of the Department of Human Services must continue to make the employer contribution for ~~hospital,~~ medical~~,~~ and dental benefits under the State Employee Group Insurance Program after the person terminates state service. If the person had dependent coverage at the time of terminating state service, employer contributions for dependent coverage also must continue under this section. The employer contributions must be in the amount of the employer contribution for active state employees at the time each payment is made. The employer contributions must continue until the person reaches age 65, provided the person makes the required employee contributions, in the amount required of an active state employee, at the time and in the manner specified by the commissioner.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to a person assaulted by an inmate, client, or patient on or after that date.

Sec. 2. Minnesota Statutes 2014, section 253B.18, subdivision 4c, is amended to read:

Subd. 4c. **Special review board.** (a) The commissioner shall establish one or more panels of a special review board. The board shall consist of three members experienced in the field of mental illness. One member of each special review board panel shall be a psychiatrist or a doctoral level psychologist with forensic experience and one member shall be an attorney. No member shall be affiliated with the Department of Human Services. The special review board shall meet at least every six months and at the call of the commissioner. It shall hear and consider all petitions for a reduction in custody or to appeal a revocation of provisional discharge. A "reduction in custody" means transfer from a secure treatment facility, discharge, and provisional discharge. Patients may be transferred by the commissioner between secure treatment facilities without a special review board hearing.

Members of the special review board shall receive compensation and reimbursement for expenses as established by the commissioner.

(b) The special review board must review each denied petition under subdivision 5 for barriers and obstacles preventing the patient from progressing in treatment. Based on the cases before the board in the previous year, the special review board shall provide to the commissioner an annual summation of the barriers to treatment progress, and recommendations to achieve the common goal of making progress in treatment.

(c) A petition filed by a person committed as mentally ill and dangerous to the public under this section must be heard as provided in subdivision 5 and, as applicable, subdivision 13. A petition filed by a person committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253D, or committed as both mentally ill and dangerous to the public under this section and as a sexual psychopathic personality or as a sexually dangerous person must be heard as provided in section 253D.27.

Sec. 3. Minnesota Statutes 2014, section 253B.18, subdivision 5, is amended to read:

Subd. 5. **Petition; notice of hearing; attendance; order.** (a) A petition for a reduction in custody or revocation of provisional discharge shall be filed with the commissioner and may be filed by the patient or by the head of the treatment facility. A patient may not petition the special review board for six months following commitment under subdivision 3 or following the final disposition of any previous petition and subsequent appeal by the patient. The head of the treatment facility must schedule a hearing before the special review board for any patient who has not appeared before the special review board in the previous three years, and schedule a hearing at least every three years thereafter. The medical director may petition at any time.

(b) Fourteen days prior to the hearing, the committing court, the county attorney of the county of commitment, the designated agency, interested person, the petitioner, and the petitioner's counsel shall be given written notice by the commissioner of the time and place of the hearing before the special review board. Only those entitled to statutory notice of the hearing or those administratively required to attend may be present at the hearing. The patient may designate interested persons to receive notice by providing the names and addresses to the commissioner at least 21 days before the hearing. The board shall provide the commissioner with written findings of fact and recommendations within 21 days of the hearing. The commissioner shall issue an order no later than 14 days after receiving the recommendation of the special review board. A copy of the order shall be mailed to every person entitled to statutory notice of the hearing within five days after it is signed. No order by the commissioner shall be effective sooner than 30 days after the order is signed, unless the county attorney, the patient, and the commissioner agree that it may become effective sooner.

(c) The special review board shall hold a hearing on each petition prior to making its recommendation to the commissioner. The special review board proceedings are not contested cases as defined in chapter 14. Any person or agency receiving notice that submits documentary evidence to the special review board prior to the hearing shall also provide copies to the patient, the patient's counsel, the county attorney of the county of commitment, the case manager, and the commissioner.

(d) Prior to the final decision by the commissioner, the special review board may be reconvened to consider events or circumstances that occurred subsequent to the hearing.

(e) In making their recommendations and order, the special review board and commissioner must consider any statements received from victims under subdivision 5a.

Sec. 4. **CLOSURE OF FACILITY PROHIBITED.**

The commissioner of human services shall not close, or otherwise terminate services at, the Community Addiction Recovery Enterprise program located in Fergus Falls earlier than July 1, 2019.

Sec. 5. **CLOSURE OF FACILITY PROHIBITED.**

The commissioner of human services shall not close, or otherwise terminate services at, the Child and Adolescent Behavioral Health Services program in Willmar without legislative approval.

ARTICLE 10

WITHDRAWAL MANAGEMENT PROGRAMS

Section 1. **[245F.01] PURPOSE.**

It is hereby declared to be the public policy of this state that the public interest is best served by providing efficient and effective withdrawal management services to persons in need of appropriate detoxification, assessment, intervention, and referral services. The services shall vary to address the unique medical needs of each patient and shall be responsive to the language and cultural needs of each patient. Services shall not be denied on the basis of a patient's inability to pay.

Sec. 2. **[245F.02] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them in this section.

Subd. 2. **Administration of medications.** "Administration of medications" means performing a task to provide medications to a patient, and includes the following tasks performed in the following order:

(1) checking the patient's medication record;

(2) preparing the medication for administration;

(3) administering the medication to the patient;

(4) documenting administration of the medication or the reason for not administering the medication as prescribed; and

(5) reporting information to a licensed practitioner or a registered nurse regarding problems with the administration of the medication or the patient's refusal to take the medication.

Subd. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" means an individual qualified under Minnesota Rules, part 9530.6450, subpart 5.

Subd. 4. **Applicant.** "Applicant" means an individual, partnership, voluntary association, corporation, or other public or private organization that submits an application for licensure under this chapter.

Subd. 5. **Care coordination.** "Care coordination" means activities intended to bring together health services, patient needs, and streams of information to facilitate the aims of care. Care coordination includes an ongoing needs assessment, life skills advocacy, treatment follow-up, disease management, education, and other services as needed.

Subd. 6. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as defined in section 152.01, subdivision 4, and other mood-altering substances.

Subd. 7. **Clinically managed program.** "Clinically managed program" means a residential setting with staff comprised of a medical director and a licensed practical nurse. A licensed practical nurse must be on site 24 hours a day, seven days a week. An individual who meets the qualification requirements of a medical director must be available by telephone or in person for consultation 24 hours a day. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; access to medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to Minnesota Rules, part 9530.6422.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services or the commissioner's designated representative.

Subd. 9. **Department.** "Department" means the Department of Human Services.

Subd. 10. **Direct patient contact.** "Direct patient contact" has the meaning given for "direct contact" in section 245C.02, subdivision 11.

Subd. 11. **Discharge plan.** "Discharge plan" means a written plan that states with specificity the services the program has arranged for the patient to transition back into the community.

Subd. 12. **Licensed practitioner.** "Licensed practitioner" means a practitioner as defined in section 151.01, subdivision 23, who is authorized to prescribe.

Subd. 13. **Medical director.** "Medical director" means an individual licensed in Minnesota as a doctor of osteopathy or physician, or an individual licensed in Minnesota as an advanced practice registered nurse by the Board of Nursing and certified to practice as a clinical nurse specialist or nurse practitioner by a national nurse organization acceptable to the board. The medical director must be employed by or under contract with the license holder to direct and supervise health care for patients of a program licensed under this chapter.

Subd. 14. **Medically monitored program.** "Medically monitored program" means a residential setting with staff that includes a registered nurse and a medical director. A registered nurse must be on site 24 hours a day. A medical director must be on site seven days a week, and patients must have the ability to be seen by a medical director within 24 hours. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment pursuant to Minnesota Rules, part 9530.6422.

Subd. 15. **Nurse.** "Nurse" means a person licensed and currently registered to practice practical or professional nursing as defined in section 148.171, subdivisions 14 and 15.

Subd. 16. **Patient.** "Patient" means an individual who presents or is presented for admission to a withdrawal management program that meets the criteria in section 245F.05.

Subd. 17. **Peer recovery support services.** "Peer recovery support services" means mentoring and education, advocacy, and nonclinical recovery support provided by a recovery peer.

Subd. 18. **Program director.** "Program director" means the individual who is designated by the license holder to be responsible for all operations of a withdrawal management program and who meets the qualifications specified in section 245F.15, subdivision 3.

Subd. 19. **Protective procedure.** "Protective procedure" means an action taken by a staff member of a withdrawal management program to protect a patient from imminent danger of harming self or others. Protective procedures include the following actions:

(1) seclusion, which means the temporary placement of a patient, without the patient's consent, in an environment to prevent social contact; and

(2) physical restraint, which means the restraint of a patient by use of physical holds intended to limit movement of the body.

Subd. 20. **Recovery peer.** "Recovery peer" means a person who has progressed in the person's own recovery from substance use disorder and is willing to serve as a peer to assist others in their recovery.

Subd. 21. **Responsible staff person.** "Responsible staff person" means the program director, the medical director, or a staff person with current licensure as a nurse in Minnesota. The responsible staff person must be on the premises and is authorized to make immediate decisions concerning patient care and safety.

Subd. 22. **Substance.** "Substance" means "chemical" as defined in subdivision 6.

Subd. 23. **Substance use disorder.** "Substance use disorder" means a pattern of substance use as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Subd. 24. **Technician.** "Technician" means a person who meets the qualifications in section 245F.15, subdivision 6.

Subd. 25. **Withdrawal management program.** "Withdrawal management program" means a licensed program that provides short-term medical services on a 24-hour basis for the purpose of stabilizing intoxicated patients, managing their withdrawal, and facilitating access to substance use disorder treatment as indicated by a comprehensive assessment.

Sec. 3. **[245F.03] APPLICATION.**

(a) This chapter establishes minimum standards for withdrawal management programs licensed by the commissioner that serve one or more unrelated persons.

(b) This chapter does not apply to a withdrawal management program licensed as a hospital under sections 144.50 to 144.581. A withdrawal management program located in a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this chapter is deemed to be in compliance with section 245F.13.

Sec. 4. **[245F.04] PROGRAM LICENSURE.**

Subdivision 1. **General application and license requirements.** An applicant for licensure as a clinically managed withdrawal management program or medically monitored withdrawal management program must meet the following requirements, except where otherwise noted. All programs must comply with federal requirements and

the general requirements in chapters 245A and 245C and sections 626.556, 626.557, and 626.5572. A withdrawal management program must be located in a hospital licensed under sections 144.50 to 144.581, or must be a supervised living facility with a class B license from the Department of Health under Minnesota Rules, chapter 4665.

Subd. 2. **Contents of application.** Prior to the issuance of a license, an applicant must submit, on forms provided by the commissioner, documentation demonstrating the following:

(1) compliance with this section;

(2) 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 this section;

(3) completion of an assessment of need for a new or expanded program as required by Minnesota Rules, part 9530.6800; and

(4) insurance coverage, including bonding, sufficient to cover all patient funds, property, and interests.

Subd. 3. **Changes in license terms.** (a) A license holder must notify the commissioner before one of the following occurs and the commissioner must determine the need for a new license:

(1) a change in the Department of Health's licensure of the program;

(2) a change in the medical services provided by the program that affects the program's capacity to provide services required by the program's license designation as a clinically managed program or medically monitored program;

(3) a change in program capacity; or

(4) a change in location.

(b) A license holder must notify the commissioner and apply for a new license when a change in program ownership occurs.

Subd. 4. **Variances.** The commissioner may grant variances to the requirements of this chapter under section 245A.04, subdivision 9.

Sec. 5. **[245F.05] ADMISSION AND DISCHARGE POLICIES.**

Subdivision 1. **Admission policy.** A license holder must have a written admission policy containing specific admission criteria. The policy must describe the admission process and the point at which an individual who is eligible under subdivision 2 is admitted to the program. A license holder must not admit individuals who do not meet the admission criteria. The admission policy must be approved and signed by the medical

director of the facility and must designate which staff members are authorized to admit and discharge patients. The admission policy must be posted in the area of the facility where patients are admitted and given to all interested individuals upon request.

Subd. 2. **Admission criteria.** For an individual to be admitted to a withdrawal management program, the program must make a determination that the program services are appropriate to the needs of the individual. A program may only admit individuals who meet the admission criteria and who, at the time of admission:

(1) are impaired as the result of intoxication;

(2) are experiencing physical, mental, or emotional problems due to intoxication or withdrawal from alcohol or other drugs;

(3) are being held under apprehend and hold orders under section 253B.07, subdivision 2b;

(4) have been committed under chapter 253B and need temporary placement;

(5) are held under emergency holds or peace and health officer holds under section 253B.05, subdivision 1 or 2; or

(6) need to stay temporarily in a protective environment because of a crisis related to substance use disorder. Individuals satisfying this clause may be admitted only at the request of the county of fiscal responsibility, as determined according to section 256G.02, subdivision 4. Individuals admitted according to this clause must not be restricted to the facility.

Subd. 3. **Individuals denied admission by program.** (a) A license holder must have a written policy and procedure for addressing the needs of individuals who are denied admission to the program. These individuals include:

(1) individuals whose pregnancy, in combination with their presenting problem, requires services not provided by the program; and

(2) individuals who are in imminent danger of harming self or others if their behavior is beyond the behavior management capabilities of the program and staff.

(b) Programs must document denied admissions, including the date and time of the admission request, reason for the denial of admission, and where the individual was referred. If the individual did not receive a referral, the program must document why a referral was not made. This information must be documented on a form approved by the commissioner and made available to the commissioner upon request.

Subd. 4. **License holder responsibilities; denying admission or terminating services.** (a) If a license holder denies an individual admission to the program or terminates services to a patient and the denial or termination poses an immediate threat to the patient's or individual's health or requires immediate medical intervention, the license

holder must refer the patient or individual to a medical facility capable of admitting the patient or individual.

(b) A license holder must report to a law enforcement agency with proper jurisdiction all denials of admission and terminations of services that involve the commission of a crime against a staff member of the license holder or on the license holder's property, as provided in Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164.

Subd. 5. **Discharge and transfer policies.** A license holder must have a written policy and procedure, approved and signed by the medical director, that specifies conditions under which patients may be discharged or transferred. The policy must include the following:

(1) guidelines for determining when a patient is medically stable and whether a patient is able to be discharged or transferred to a lower level of care;

(2) guidelines for determining when a patient needs a transfer to a higher level of care. Clinically managed program guidelines must include guidelines for transfer to a medically monitored program, hospital, or other acute care facility. Medically monitored program guidelines must include guidelines for transfer to a hospital or other acute care facility;

(3) procedures staff must follow when discharging a patient under each of the following circumstances:

(i) the patient is involved in the commission of a crime against program staff or against a license holder's property. The procedures for a patient discharged under this item must specify how reports must be made to law enforcement agencies with proper jurisdiction as allowed under Code of Federal Regulations, title 42, section 2.12(c)(5), and title 45, parts 160 to 164;

(ii) the patient is in imminent danger of harming self or others and is beyond the license holder's capacity to ensure safety;

(iii) the patient was admitted under chapter 253B; or

(iv) the patient is leaving against staff or medical advice; and

(4) a requirement that staff must document where the patient was referred after discharge or transfer, and if a referral was not made, the reason the patient was not provided a referral.

Sec. 6. **[245F.06] SCREENING AND COMPREHENSIVE ASSESSMENT.**

Subdivision 1. **Screening for substance use disorder.** A nurse or an alcohol and drug counselor must screen each patient upon admission to determine whether a comprehensive assessment is indicated. The license holder must screen patients at

each admission, except that if the patient has already been determined to suffer from a substance use disorder, subdivision 2 applies.

Subd. 2. **Comprehensive assessment.** (a) Prior to a medically stable discharge, but not later than 72 hours following admission, a license holder must provide a comprehensive assessment according to section 245.4863, paragraph (a), and Minnesota Rules, part 9530.6422, for each patient who has a positive screening for a substance use disorder. If a patient's medical condition prevents a comprehensive assessment from being completed within 72 hours, the license holder must document why the assessment was not completed. The comprehensive assessment must include documentation of the appropriateness of an involuntary referral through the civil commitment process.

(b) If available to the program, a patient's previous comprehensive assessment may be used in the patient record. If a previously completed comprehensive assessment is used, its contents must be reviewed to ensure the assessment is accurate and current and complies with the requirements of this chapter. The review must be completed by a staff person qualified according to Minnesota Rules, part 9530.6450, subpart 5. The license holder must document that the review was completed and that the previously completed assessment is accurate and current, or the license holder must complete an updated or new assessment.

Sec. 7. **[245F.07] STABILIZATION PLANNING.**

Subdivision 1. **Stabilization plan.** Within 12 hours of admission, a license holder must develop an individualized stabilization plan for each patient accepted for stabilization services. The plan must be based on the patient's initial health assessment and continually updated based on new information gathered about the patient's condition from the comprehensive assessment, medical evaluation and consultation, and ongoing monitoring and observations of the patient. The patient must have an opportunity to have direct involvement in the development of the plan. The stabilization plan must:

(1) identify medical needs and goals to be achieved while the patient is receiving services;

(2) specify stabilization services to address the identified medical needs and goals, including amount and frequency of services;

(3) specify the participation of others in the stabilization planning process and specific services where appropriated; and

(4) document the patient's participation in developing the content of the stabilization plan and any updates.

Subd. 2. **Progress notes.** Progress notes must be entered in the patient's file at least daily and immediately following any significant event, including any change that impacts the medical, behavioral, or legal status of the patient. Progress notes must:

(1) include documentation of the patient's involvement in the stabilization services, including the type and amount of each stabilization service;

(2) include the monitoring and observations of the patient's medical needs;

(3) include documentation of referrals made to other services or agencies;

(4) specify the participation of others; and

(5) be legible, signed, and dated by the staff person completing the documentation.

Subd. 3. **Discharge plan.** Before a patient leaves the facility, the license holder must conduct discharge planning for the patient, document discharge planning in the patient's record, and provide the patient with a copy of the discharge plan. The discharge plan must include:

(1) referrals made to other services or agencies at the time of transition;

(2) the patient's plan for follow-up, aftercare, or other poststabilization services;

(3) documentation of the patient's participation in the development of the transition plan;

(4) any service that will continue after discharge under the direction of the license holder; and

(5) a stabilization summary and final evaluation of the patient's progress toward treatment objectives.

Sec. 8. **[245F.08] STABILIZATION SERVICES.**

Subdivision 1. **General.** The license holder must encourage patients to remain in care for an appropriate duration as determined by the patient's stabilization plan, and must encourage all patients to enter programs for ongoing recovery as clinically indicated. In addition, the license holder must offer services that are patient-centered, trauma-informed, and culturally appropriate. Culturally appropriate services must include translation services and dietary services that meet a patient's dietary needs. All services provided to the patient must be documented in the patient's medical record. The following services must be offered unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual or group motivational counseling sessions;

(2) individual advocacy and case management services;

(3) medical services as required in section 245F.12;

(4) care coordination provided according to subdivision 2;

(5) peer recovery support services provided according to subdivision 3;

(6) patient education provided according to subdivision 4; and

(7) referrals to mutual aid, self-help, and support groups.

Subd. 2. **Care coordination.** Care coordination services must be initiated for each patient upon admission. The license holder must identify the staff person responsible for the provision of each service. Care coordination services must include:

(1) coordination with significant others to assist in the stabilization planning process whenever possible;

(2) coordination with and follow-up to appropriate medical services as identified by the nurse or licensed practitioner;

(3) referral to substance use disorder services as indicated by the comprehensive assessment;

(4) referral to mental health services as identified in the comprehensive assessment;

(5) referrals to economic assistance, social services, and prenatal care in accordance with the patient's needs;

(6) review and approval of the transition plan prior to discharge, except in an emergency, by a staff member able to provide direct patient contact;

(7) documentation of the provision of care coordination services in the patient's file; and

(8) addressing cultural and socioeconomic factors affecting the patient's access to services.

Subd. 3. **Peer recovery support services.** (a) Peers in recovery serve as mentors or recovery-support partners for individuals in recovery, and may provide encouragement, self-disclosure of recovery experiences, transportation to appointments, assistance with finding resources that will help locate housing, job search resources, and assistance finding and participating in support groups.

(b) Peer recovery support services are provided by a recovery peer and must be supervised by the responsible staff person.

Subd. 4. **Patient education.** A license holder must provide education to each patient on the following:

(1) substance use disorder, including the effects of alcohol and other drugs, specific information about the effects of substance use on unborn children, and the signs and symptoms of fetal alcohol spectrum disorders;

(2) tuberculosis and reporting known cases of tuberculosis disease to health care authorities according to section 144.4804;

(3) Hepatitis C treatment and prevention;

(4) HIV as required in section 245A.19, paragraphs (b) and (c);

(5) nicotine cessation options, if applicable;

(6) opioid tolerance and overdose risks, if applicable; and

(7) long-term withdrawal issues related to use of barbiturates and benzodiazepines, if applicable.

Subd. 5. **Mutual aid, self-help, and support groups.** The license holder must refer patients to mutual aid, self-help, and support groups when clinically indicated and to the extent available in the community.

Sec. 9. **[245F.09] PROTECTIVE PROCEDURES.**

Subdivision 1. **Use of protective procedures.** (a) Programs must incorporate person-centered planning and trauma-informed care into its protective procedure policies. Protective procedures may be used only in cases where a less restrictive alternative will not protect the patient or others from harm and when the patient is in imminent danger of harming self or others. When a program uses a protective procedure, the program must continuously observe the patient until the patient may safely be left for 15-minute intervals. Use of the procedure must end when the patient is no longer in imminent danger of harming self or others.

(b) Protective procedures may not be used:

(1) for disciplinary purposes;

(2) to enforce program rules;

(3) for the convenience of staff;

(4) as a part of any patient's health monitoring plan; or

(5) for any reason except in response to specific, current behaviors which create an imminent danger of harm to the patient or others.

Subd. 2. **Protective procedures plan.** A license holder must have a written policy and procedure that establishes the protective procedures that program staff must follow when a patient is in imminent danger of harming self or others. The policy must be appropriate to the type of facility and the level of staff training. The protective procedures policy must include:

(1) an approval signed and dated by the program director and medical director prior to implementation. Any changes to the policy must also be approved, signed, and dated by the current program director and the medical director prior to implementation;

(2) which protective procedures the license holder will use to prevent patients from imminent danger of harming self or others;

(3) the emergency conditions under which the protective procedures are permitted to be used, if any;

(4) the patient's health conditions that limit the specific procedures that may be used and alternative means of ensuring safety;

(5) emergency resources the program staff must contact when a patient's behavior cannot be controlled by the procedures established in the policy;

(6) the training that staff must have before using any protective procedure;

(7) documentation of approved therapeutic holds;

(8) the use of law enforcement personnel as described in subdivision 4;

(9) standards governing emergency use of seclusion. Seclusion must be used only when less restrictive measures are ineffective or not feasible. The standards in items (i) to (vii) must be met when seclusion is used with a patient:

(i) seclusion must be employed solely for the purpose of preventing a patient from imminent danger of harming self or others;

(ii) seclusion rooms must be equipped in a manner that prevents patients from self-harm using projections, windows, electrical fixtures, or hard objects, and must allow the patient to be readily observed without being interrupted;

(iii) seclusion must be authorized by the program director, a licensed physician, or a registered nurse. If one of these individuals is not present in the facility, the program director or a licensed physician or registered nurse must be contacted and authorization must be obtained within 30 minutes of initiating seclusion, according to written policies;

(iv) patients must not be placed in seclusion for more than 12 hours at any one time;

(v) once the condition of a patient in seclusion has been determined to be safe enough to end continuous observation, a patient in seclusion must be observed at a minimum of every 15 minutes for the duration of seclusion and must always be within hearing range of program staff;

(vi) a process for program staff to use to remove a patient to other resources available to the facility if seclusion does not sufficiently assure patient safety; and

(vii) a seclusion area may be used for other purposes, such as intensive observation, if the room meets normal standards of care for the purpose and if the room is not locked; and

(10) physical holds may only be used when less restrictive measures are not feasible. The standards in items (i) to (iv) must be met when physical holds are used with a patient:

(i) physical holds must be employed solely for preventing a patient from imminent danger of harming self or others;

(ii) physical holds must be authorized by the program director, a licensed physician, or a registered nurse. If one of these individuals is not present in the facility, the program director or a licensed physician or a registered nurse must be contacted and authorization

must be obtained within 30 minutes of initiating a physical hold, according to written policies;

(iii) the patient's health concerns must be considered in deciding whether to use physical holds and which holds are appropriate for the patient; and

(iv) only approved holds may be utilized. Prone holds are not allowed and must not be authorized.

Subd. 3. **Records.** Each use of a protective procedure must be documented in the patient record. The patient record must include:

(1) a description of specific patient behavior precipitating a decision to use a protective procedure, including date, time, and program staff present;

(2) the specific means used to limit the patient's behavior;

(3) the time the protective procedure began, the time the protective procedure ended, and the time of each staff observation of the patient during the procedure;

(4) the names of the program staff authorizing the use of the protective procedure, the time of the authorization, and the program staff directly involved in the protective procedure and the observation process;

(5) a brief description of the purpose for using the protective procedure, including less restrictive interventions used prior to the decision to use the protective procedure and a description of the behavioral results obtained through the use of the procedure. If a less restrictive intervention was not used, the reasons for not using a less restrictive intervention must be documented;

(6) documentation by the responsible staff person on duty of reassessment of the patient at least every 15 minutes to determine if seclusion or the physical hold can be terminated;

(7) a description of the physical holds used in escorting a patient; and

(8) any injury to the patient that occurred during the use of a protective procedure.

Subd. 4. **Use of law enforcement.** The program must maintain a central log documenting each incident involving use of law enforcement, including:

(1) the date and time law enforcement arrived at and left the program;

(2) the reason for the use of law enforcement;

(3) if law enforcement used force or a protective procedure and which protective procedure was used; and

(4) whether any injuries occurred.

Subd. 5. **Administrative review.** (a) The license holder must keep a record of all patient incidents and protective procedures used. An administrative review of each use of protective procedures must be completed within 72 hours by someone other than the

person who used the protective procedure. The record of the administrative review of the use of protective procedures must state whether:

(1) the required documentation was recorded for each use of a protective procedure;

(2) the protective procedure was used according to the policy and procedures;

(3) the staff who implemented the protective procedure was properly trained; and

(4) the behavior met the standards for imminent danger of harming self or others.

(b) The license holder must conduct and document a quarterly review of the use of protective procedures with the goal of reducing the use of protective procedures. The review must include:

(1) any patterns or problems indicated by similarities in the time of day, day of the week, duration of the use of a protective procedure, individuals involved, or other factors associated with the use of protective procedures;

(2) any injuries resulting from the use of protective procedures;

(3) whether law enforcement was involved in the use of a protective procedure;

(4) actions needed to correct deficiencies in the program's implementation of protective procedures;

(5) an assessment of opportunities missed to avoid the use of protective procedures; and

(6) proposed actions to be taken to minimize the use of protective procedures.

Sec. 10. **[245F.10] PATIENT RIGHTS AND GRIEVANCE PROCEDURES.**

Subdivision 1. **Patient rights.** Patients have the rights in sections 144.651, 148F.165, and 253B.03, as applicable. The license holder must give each patient, upon admission, a written statement of patient rights. Program staff must review the statement with the patient.

Subd. 2. **Grievance procedure.** Upon admission, the license holder must explain the grievance procedure to the patient or patient's representative. The grievance procedure must be posted in a place visible to the patient and must be made available to current and former patients upon request. A license holder's written grievance procedure must include:

(1) staff assistance in developing and processing the grievance;

(2) an initial response to the patient who filed the grievance within 24 hours of the program's receipt of the grievance, and timelines for additional steps to be taken to resolve the grievance, including access to the person with the highest level of authority in the program if the grievance cannot be resolved by other staff members; and

(3) the addresses and telephone numbers of the Department of Human Services Licensing Division, Department of Health Office of Health Facilities Complaints, Board

of Behavioral Health and Therapy, Board of Medical Practice, Board of Nursing, and Office of the Ombudsman for Mental Health and Developmental Disabilities.

Sec. 11. **[245F.11] PATIENT PROPERTY MANAGEMENT.**

A license holder must meet the requirements for handling patient funds and property in section 245A.04, subdivision 13, except:

(1) a license holder must establish policies regarding the use of personal property to assure that program activities and the rights of other patients are not infringed, and may take temporary custody of personal property if these policies are violated;

(2) a license holder must retain the patient's property for a minimum of seven days after discharge if the patient does not reclaim the property after discharge; and

(3) the license holder must return to the patient all of the patient's property held in trust at discharge, regardless of discharge status, except that:

(i) drugs, drug paraphernalia, and drug containers that are forfeited under 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, sections 2.1 to 2.67, and title 45, parts 160 to 164; and

(ii) weapons, explosives, and other property that may cause serious harm to self or others must be transferred to a local law enforcement agency. The patient must be notified of the transfer and the right to reclaim the property if the patient has a legal right to possess the item.

Sec. 12. **[245F.12] MEDICAL SERVICES.**

Subdivision 1. **Services provided at all programs.** Withdrawal management programs must have:

(1) a standardized data collection tool for collecting health-related information about each patient. The data collection tool must be developed in collaboration with a registered nurse and approved and signed by the medical director; and

(2) written procedures for a nurse to assess and monitor patient health within the nurse's scope of practice. The procedures must:

(i) be approved by the medical director;

(ii) include a follow-up screening conducted between four and 12 hours after service initiation to collect information relating to acute intoxication, other health complaints, and behavioral risk factors that the patient may not have communicated at service initiation;

(iii) specify the physical signs and symptoms that, when present, require consultation with a registered nurse or a physician and that require transfer to an acute care facility or a higher level of care than that provided by the program;

(iv) specify those staff members responsible for monitoring patient health and provide for hourly observation and for more frequent observation if the initial health assessment or follow-up screening indicates a need for intensive physical or behavioral health monitoring; and

(v) specify the actions to be taken to address specific complicating conditions, including pregnancy or the presence of physical signs or symptoms of any other medical condition.

Subd. 2. **Services provided at clinically managed programs.** In addition to the services listed in subdivision 1, clinically managed programs must:

(1) have a licensed practical nurse on site 24 hours a day and a medical director;

(2) provide an initial health assessment conducted by a nurse upon admission;

(3) provide daily on-site medical evaluation and consultation with a registered nurse and have a registered nurse available by telephone or in person for consultation 24 hours a day;

(4) have an individual who meets the qualification requirements of a medical director available by telephone or in person for consultation 24 hours a day; and

(5) have appropriately licensed staff available to administer medications according to prescriber-approved orders.

Subd. 3. **Services provided at medically monitored programs.** In addition to the services listed in subdivision 1, medically monitored programs must have a registered nurse on site 24 hours a day and a medical director. Medically monitored programs must provide intensive inpatient withdrawal management services which must include:

(1) an initial health assessment conducted by a registered nurse upon admission;

(2) the availability of a medical evaluation and consultation with a registered nurse 24 hours a day;

(3) the availability of a licensed professional who meets the qualification requirements of a medical director by telephone or in person for consultation 24 hours a day;

(4) the ability to be seen within 24 hours or sooner by an individual who meets the qualification requirements of a medical director if the initial health assessment indicates the need to be seen;

(5) the availability of on-site monitoring of patient care seven days a week by an individual who meets the qualification requirements of a medical director; and

(6) appropriately licensed staff available to administer medications according to prescriber-approved orders.

Sec. 13. **[245F.13] MEDICATIONS.**

Subdivision 1. **Administration of medications.** A license holder must employ or contract with a registered nurse to develop the policies and procedures for medication administration. A registered nurse must provide supervision as defined in section 148.171, subdivision 23, for the administration of medications. For clinically managed programs, the registered nurse supervision must include on-site supervision at least monthly or more often as warranted by the health needs of the patient. The medication administration policies and procedures must include:

(1) a provision that patients may carry emergency medication such as nitroglycerin as instructed by their prescriber;

(2) requirements for recording the patient's use of medication, including staff signatures with date and time;

(3) guidelines regarding when to inform a licensed practitioner or a registered nurse of problems with medication administration, including failure to administer, patient refusal of a medication, adverse reactions, or errors; and

(4) procedures for acceptance, documentation, and implementation of prescriptions, whether written, oral, telephonic, or electronic.

Subd. 2. **Control of drugs.** A license holder must have in place and implement written policies and procedures relating to control of drugs. The policies and procedures must be developed by a registered nurse and must contain the following provisions:

(1) a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined in section 152.02, subdivision 3, must be stored in a separately locked compartment that is permanently affixed to the physical plant or a medication cart;

(2) a system for accounting for all scheduled drugs each shift;

(3) a procedure for recording a patient's use of medication, including staff signatures with time and date;

(4) a procedure for destruction of discontinued, outdated, or deteriorated medications;

(5) a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

(6) a statement that no legend drug supply for one patient may be given to another patient.

Sec. 14. **[245F.14] STAFFING REQUIREMENTS AND DUTIES.**

Subdivision 1. **Program director.** A license holder must employ or contract with a person, on a full-time basis, to serve as program director. The program director must be responsible for all aspects of the facility and the services delivered to the license holder's patients. An individual may serve as program director for more than one program owned by the same license holder.

Subd. 2. **Responsible staff person.** During all hours of operation, a license holder must designate a staff member as the responsible staff person to be present and awake in the facility and be responsible for the program. The responsible staff person must have decision-making authority over the day-to-day operation of the program as well as the authority to direct the activity of or terminate the shift of any staff member who has direct patient contact.

Subd. 3. **Technician required.** A license holder must have one technician awake and on duty at all times for every ten patients in the program. A license holder may assign technicians according to the need for care of the patients, except that the same technician must not be responsible for more than 15 patients at one time. For purposes of establishing this ratio, all staff whose qualifications meet or exceed those for technicians under section 245F.15, subdivision 6, and who are performing the duties of a technician may be counted as technicians. The same individual may not be counted as both a technician and an alcohol and drug counselor.

Subd. 4. **Registered nurse required.** A license holder must employ or contract with a registered nurse, who must be available 24 hours a day by telephone or in person for consultation. The registered nurse is responsible for:

(1) establishing and implementing procedures for the provision of nursing care and delegated medical care, including:

(i) a health monitoring plan;

(ii) a medication control plan;

(iii) training and competency evaluations for staff performing delegated medical and nursing functions;

(iv) handling serious illness, accident, or injury to patients;

(v) an infection control program; and

(vi) a first aid kit;

(2) delegating nursing functions to other staff consistent with their education, competence, and legal authorization;

(3) assigning, supervising, and evaluating the performance of nursing tasks; and

(4) implementing condition-specific protocols in compliance with section 151.37, subdivision 2.

Subd. 5. **Medical director required.** A license holder must have a medical director available for medical supervision. The medical director is responsible for ensuring the accurate and safe provision of all health-related services and procedures. A license holder must obtain and document the medical director's annual approval of the following procedures before the procedures may be used:

(1) admission, discharge, and transfer criteria and procedures;

(2) a health services plan;

(3) physical indicators for a referral to a physician, registered nurse, or hospital, and procedures for referral;

(4) procedures to follow in case of accident, injury, or death of a patient;

(5) formulation of condition-specific protocols regarding the medications that require a withdrawal regimen that will be administered to patients;

(6) an infection control program;

(7) protective procedures; and

(8) a medication control plan.

Subd. 6. **Alcohol and drug counselor.** A withdrawal management program must provide one full-time equivalent alcohol and drug counselor for every 16 patients served by the program.

Subd. 7. **Ensuring staff-to-patient ratio.** The responsible staff person under subdivision 2 must ensure that the program does not exceed the staff-to-patient ratios in subdivisions 3 and 6 and must inform admitting staff of the current staffed capacity of the program for that shift. A license holder must have a written policy for documenting staff-to-patient ratios for each shift and actions to take when staffed capacity is reached.

Sec. 15. **[245F.15] STAFF QUALIFICATIONS.**

Subdivision 1. **Qualifications for all staff who have direct patient contact.** (a) All staff who have direct patient contact must be at least 18 years of age and must, at the time of hiring, document that they meet the requirements in paragraph (b), (c), or (d).

(b) Program directors, supervisors, nurses, and alcohol and drug counselors must be free of substance use problems for at least two years immediately preceding their hiring and must sign a statement attesting to that fact.

(c) Recovery peers must be free of substance use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.

(d) Technicians and other support staff must be free of substance use problems for at least six months immediately preceding their hiring and must sign a statement attesting to that fact.

Subd. 2. **Continuing employment; no substance use problems.** License holders must require staff to be free from substance use problems as a condition of continuing employment. Staff are not required to sign statements attesting to their freedom from substance use problems after the initial statement required by subdivision 1. Staff with substance use problems must be immediately removed from any responsibilities that include direct patient contact.

Subd. 3. **Program director qualifications.** A program director must:

(1) have at least one year of work experience in direct service to individuals with substance use disorders or one year of work experience in the management or administration of direct service to individuals with substance use disorders;

(2) have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services; and

(3) know and understand the implications of this chapter and chapters 245A and 245C, and sections 253B.04, 253B.05, 626.556, 626.557, and 626.5572.

Subd. 4. **Alcohol and drug counselor qualifications.** An alcohol and drug counselor must meet the requirements in Minnesota Rules, part 9530.6450, subpart 5.

Subd. 5. **Responsible staff person qualifications.** Each responsible staff person must know and understand the implications of this chapter and sections 245A.65, 253B.04, 253B.05, 626.556, 626.557, and 626.5572. In a clinically managed program, the responsible staff person must be a licensed practiced nurse employed by or under contract with the license holder. In a medically monitored program, the responsible staff person must be a registered nurse, program director, or physician.

Subd. 6. **Technician qualifications.** A technician employed by a program must demonstrate competency, prior to direct patient contact, in the following areas:

(1) knowledge of the client bill of rights in section 148F.165 and staff responsibilities in sections 144.651 and 253B.03;

(2) knowledge of and the ability to perform basic health screening procedures with intoxicated patients that consist of:

(i) blood pressure, pulse, temperature, and respiration readings;

(ii) interviewing to obtain relevant medical history and current health complaints; and

(iii) visual observation of a patient's health status, including monitoring a patient's behavior as it relates to health status;

(3) a current first aid certificate from the American Red Cross or an equivalent organization; a current cardiopulmonary resuscitation certificate from the American Red Cross, the American Heart Association, a community organization, or an equivalent organization; and knowledge of first aid for seizures, trauma, and loss of consciousness; and

(4) knowledge of and ability to perform basic activities of daily living and personal hygiene.

Subd. 7. **Recovering peer qualifications.** Recovery peers must:

(1) be at least 21 years of age and have a high school diploma or its equivalent;

(2) have a minimum of one year in recovery from substance use disorder;

(3) have completed a curriculum designated by the commissioner that teaches specific skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and

(4) receive supervision in areas specific to the domains of their role by qualified supervisory staff.

Subd. 8. **Personal relationships.** A license holder must have a written policy addressing personal relationships between patients and staff who have direct patient contact. The policy must:

(1) prohibit direct patient contact between a patient and a staff member if the staff member has had a personal relationship with the patient within two years prior to the patient's admission to the program;

(2) prohibit access to a patient's clinical records by a staff member who has had a personal relationship with the patient within two years prior to the patient's admission, unless the patient consents in writing; and

(3) prohibit a clinical relationship between a staff member and a patient if the staff member has had a personal relationship with the patient within two years prior to the patient's admission. If a personal relationship exists, the staff member must report the relationship to the staff member's supervisor and recuse the staff member from a clinical relationship with that patient.

Sec. 16. **[245F.16] PERSONNEL POLICIES AND PROCEDURES.**

Subdivision 1. **Policy requirements.** A license holder must have written personnel policies and must make them available to staff members at all times. The personnel policies must:

(1) ensure that staff member's retention, promotion, job assignment, or pay are not affected by a good faith communication between the staff member and the Department of Human Services, Department of Health, Ombudsman for Mental Health and Developmental Disabilities, law enforcement, or local agencies that investigate complaints regarding patient rights, health, or safety;

(2) include a job description for each position that specifies job responsibilities, degree of authority to execute job responsibilities, standards of job performance related to specified job responsibilities, and qualifications;

(3) provide for written job performance evaluations for staff members of the license holder at least annually;

(4) describe behavior that constitutes grounds for disciplinary action, suspension, or dismissal, including policies that address substance use problems and meet the requirements of section 245F.15, subdivisions 1 and 2. The policies and procedures must list behaviors or incidents that are considered substance use problems. The list must include:

(i) receiving treatment for substance use disorder within the period specified for the position in the staff qualification requirements;

(ii) substance use that has a negative impact on the staff member's job performance;

(iii) substance use that affects the credibility of treatment services with patients, referral sources, or other members of the community; and

(iv) symptoms of intoxication or withdrawal on the job;

(5) include policies prohibiting personal involvement with patients and policies prohibiting patient maltreatment as specified under chapter 604 and sections 245A.65, 626.556, 626.557, and 626.5572;

(6) include a chart or description of organizational structure indicating the lines of authority and responsibilities;

(7) include a written plan for new staff member orientation that, at a minimum, includes training related to the specific job functions for which the staff member was hired, program policies and procedures, patient needs, and the areas identified in subdivision 2, paragraphs (b) to (e); and

(8) include a policy on the confidentiality of patient information.

Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member receives orientation training before providing direct patient care and at least 30 hours of continuing education every two years. A written record must be kept to demonstrate completion of training requirements.

(b) Within 72 hours of beginning employment, all staff having direct patient contact must be provided orientation on the following:

(1) specific license holder and staff responsibilities for patient confidentiality;

(2) standards governing the use of protective procedures;

(3) patient ethical boundaries and patient rights, including the rights of patients admitted under chapter 253B;

(4) infection control procedures;

(5) mandatory reporting under sections 245A.65, 626.556, and 626.557, including specific training covering the facility's policies concerning obtaining patient releases of information;

(6) HIV minimum standards as required in section 245A.19;

(7) motivational counseling techniques and identifying stages of change; and

(8) eight hours of training on the program's protective procedures policy required in section 245F.09, including:

(i) approved therapeutic holds;

(ii) protective procedures used to prevent patients from imminent danger of harming self or others;

(iii) the emergency conditions under which the protective procedures may be used, if any;

(iv) documentation standards for using protective procedures;

(v) how to monitor and respond to patient distress; and

(vi) person-centered planning and trauma-informed care.

(c) All staff having direct patient contact must be provided annual training on the following:

(1) infection control procedures;

(2) mandatory reporting under sections 245A.65, 626.556, and 626.557, including specific training covering the facility's policies concerning obtaining patient releases of information;

(3) HIV minimum standards as required in section 245A.19; and

(4) motivational counseling techniques and identifying stages of change.

(d) All staff having direct patient contact must be provided training every two years on the following:

(1) specific license holder and staff responsibilities for patient confidentiality;

(2) standards governing use of protective procedures, including:

(i) approved therapeutic holds;

(ii) protective procedures used to prevent patients from imminent danger of harming self or others;

(iii) the emergency conditions under which the protective procedures may be used, if any;

(iv) documentation standards for using protective procedures;

(v) how to monitor and respond to patient distress; and

(vi) person-centered planning and trauma-informed care; and

(3) patient ethical boundaries and patient rights, including the rights of patients admitted under chapter 253B.

(e) Continuing education that is completed in areas outside of the required topics must provide information to the staff person that is useful to the performance of the individual staff person's duties.

Sec. 17. **[245F.18] POLICY AND PROCEDURES MANUAL.**

A license holder must develop a written policy and procedures manual that is alphabetically indexed and has a table of contents, so that staff have immediate access to all policies and procedures, and that consumers of the services and other authorized parties have access to all policies and procedures. The manual must contain the following materials:

(1) a description of patient education services as required in section 245F.06;

(2) personnel policies that comply with section 245F.16;

(3) admission information and referral and discharge policies that comply with section 245F.05;

(4) a health monitoring plan that complies with section 245F.12;

(5) a protective procedures policy that complies with section 245F.09, if the program elects to use protective procedures;

(6) policies and procedures for assuring appropriate patient-to-staff ratios that comply with section 245F.14;

(7) policies and procedures for assessing and documenting the susceptibility for risk of abuse to the patient as the basis for the individual abuse prevention plan required by section 245A.65;

(8) procedures for mandatory reporting as required by sections 245A.65, 626.556, and 626.557;

(9) a medication control plan that complies with section 245F.13; and

(10) policies and procedures regarding HIV that meet the minimum standards under section 245A.19.

Sec. 18. **[245F.21] PAYMENT METHODOLOGY.**

The commissioner shall develop a payment methodology for services provided under this chapter or by an Indian Health Services facility or a facility owned and operated by a tribe or tribal organization operating under Public Law 93-638 as a 638 facility. The commissioner shall seek federal approval for the methodology. Upon federal approval, the

commissioner must seek and obtain legislative approval of the funding methodology to support the service.

ARTICLE 11

HEALTH-RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2014, section 146B.01, subdivision 28, is amended to read:

Subd. 28. **Supervision.** "Supervision" means the physical presence of a technician licensed under this chapter while a body art procedure is being performed- and includes:

(1) direct supervision, which means the constant physical presence of a technician licensed under this chapter within five feet and the line of sight of the temporary technician who is performing a body art procedure; and

(2) indirect supervision, which means the constant physical presence of a technician licensed under this chapter in the establishment while a body art procedure is being performed by a temporary technician.

Sec. 2. Minnesota Statutes 2014, section 146B.03, subdivision 4, is amended to read:

Subd. 4. **Licensure requirements.** (a) An applicant for licensure under this section shall submit to the commissioner on a form provided by the commissioner:

(1) proof that the applicant is over the age of 18;

(2) the type of license the applicant is applying for;

(3) all fees required under section 146B.10;

(4) proof of completing a minimum of 200 hours of supervised experience within each area for which the applicant is seeking a license, and must include an affidavit from the supervising licensed technician;

(5) proof of having satisfactorily completed coursework within the year preceding application and approved by the commissioner on bloodborne pathogens, the prevention of disease transmission, infection control, and aseptic technique. Courses to be considered for approval by the commissioner may include, but are not limited to, those administered by one of the following:

(i) the American Red Cross;

(ii) United States Occupational Safety and Health Administration (OSHA); or

(iii) the Alliance of Professional Tattooists; and

(6) any other relevant information requested by the commissioner.

The licensure requirements of this paragraph are effective for all applicants for new licenses issued before January 1, 2016.

(b) An applicant for licensure under this section shall submit to the commissioner on a form provided by the commissioner:

(1) proof that the applicant is over the age of 18;

(2) the type of license the applicant is applying for;

(3) all fees required under section 146B.10;

(4) a log showing completion of the supervised experience as specified in subdivision 12;

(5) a signed affidavit from each licensed technician who the applicant listed as providing supervision for each required activity;

(6) proof of having satisfactorily completed a minimum of five hours of coursework, within the year preceding application and approved by the commissioner, on bloodborne pathogens, the prevention of disease transmission, infection control, and aseptic technique. Courses to be considered for approval by the commissioner may include, but are not limited to, those administered by one of the following:

(i) the American Red Cross;

(ii) the United States Occupational Safety and Health Administration (OSHA); or

(iii) the Alliance of Professional Tattooists; and

(7) any other relevant information requested by the commissioner.

The licensure requirements of this paragraph shall be effective for all applicants for new licenses issued on or after January 1, 2016.

Sec. 3. Minnesota Statutes 2014, section 146B.03, subdivision 6, is amended to read:

Subd. 6. **Licensure term; renewal.** (a) A technician's license is valid for two years from the date of issuance and may be renewed upon payment of the renewal fee established under section 146B.10.

(b) At renewal, a licensee must submit proof of continuing education approved by the commissioner in the areas identified in subdivision 4, paragraph (b), clause ~~(5)~~ (6).

(c) The commissioner shall notify the technician of the pending expiration of a technician license at least 90 days prior to license expiration.

Sec. 4. Minnesota Statutes 2014, section 146B.03, is amended by adding a subdivision to read:

Subd. 12. **Required supervised experience.** An applicant for a body art technician license shall complete the following minimum supervised experience for licensure:

(1) an applicant for a tattoo technician license or a dual body art technician license must complete a minimum of 200 hours of tattoo experience under supervision; and

(2) an applicant for a body piercing technician license or a dual body art technician license must perform 250 body piercings under direct supervision and 250 body piercings under indirect supervision.

Sec. 5. Minnesota Statutes 2014, section 146B.07, subdivision 1, is amended to read:

Subdivision 1. **Proof of age.** (a) A technician shall require proof of age from clients who state they are 18 years of age or older before performing any body art procedure on a client. Proof of age must be established by one of the following methods:

(1) a valid driver's license or identification card issued by the state of Minnesota or another state that includes a photograph and date of birth of the individual;

(2) a valid military identification card issued by the United States Department of Defense;

(3) a valid passport;

(4) a resident alien card; or

(5) a tribal identification card.

(b) Before performing any body art procedure, the technician must provide the client with a disclosure and authorization form that indicates whether the client has:

(1) diabetes;

(2) a history of hemophilia;

(3) a history of skin diseases, skin lesions, or skin sensitivities to soap or disinfectants;

(4) a history of epilepsy, seizures, fainting, or narcolepsy;

(5) any condition that requires the client to take medications such as anticoagulants that thin the blood or interfere with blood clotting; or

(6) any other information that would aid the technician in the body art procedure process evaluation.

(c) The form must include a statement informing the client that the technician shall not perform a body art procedure if the client fails to complete or sign the disclosure and authorization form, and the technician may decline to perform a body art procedure if the client has any identified health conditions.

(d) The technician shall ask the client to sign and date the disclosure and authorization form confirming that the information listed on the form is accurate.

(e) Before performing any body art procedure, the technician shall offer and make available to the client personal draping, as appropriate.

Sec. 6. Minnesota Statutes 2014, section 146B.07, subdivision 2, is amended to read:

Subd. 2. **Parent or legal guardian consent; prohibitions.** (a) A technician may perform body piercings on an individual under the age of 18 ~~if~~ when:

(1) the individual's parent or legal guardian is present ~~and~~;

(2) the parent or legal guardian provides personal identification as provided in subdivision 1, paragraph (a), clauses (1) to (5);

(3) the individual under age 18 provides proof of identification and age as provided in subdivision 1, paragraph (a), clauses (1) to (5), by a current student identification, or by another method that includes a photograph and the name of the individual from an official source;

(4) the parent or legal guardian provides other documentation to reasonably establish that the individual is the parent or the legal guardian of the individual under age 18 who is seeking a body piercing;

(5) a consent form and the authorization form under subdivision 1, paragraph (b) is signed by the parent or legal guardian in the presence of the technician~~.~~; and

(6) the piercing is not prohibited under paragraph (c).

(b) No technician shall tattoo any individual under the age of 18 regardless of parental or guardian consent.

(c) No nipple or genital piercing, branding, scarification, suspension, subdermal implantation, microdermal, or tongue bifurcation shall be performed by any technician on any individual under the age of 18 regardless of parental or guardian consent.

(d) No technician shall perform body art procedures on any individual who appears to be under the influence of alcohol, controlled substances as defined in section 152.01, subdivision 4, or hazardous substances as defined in rules adopted under chapter 182.

(e) No technician shall perform body art procedures while under the influence of alcohol, controlled substances as defined under section 152.01, subdivision 4, or hazardous substances as defined in the rules adopted under chapter 182.

(f) No technician shall administer anesthetic injections or other medications.

Sec. 7. Minnesota Statutes 2014, section 147.091, subdivision 1, is amended to read:

Subdivision 1. **Grounds listed.** The board may refuse to grant a license, may refuse to grant registration to perform interstate telemedicine services, or may impose disciplinary action as described in section 147.141 against any physician. The following conduct is prohibited and is grounds for disciplinary action:

(a) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. The burden of proof shall be upon the applicant to demonstrate such qualifications or satisfaction of such requirements.

(b) Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process. Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to: (1) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (2) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (3) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(c) Conviction, during the previous five years, of a felony reasonably related to the practice of medicine or osteopathy. Conviction as used in this subdivision shall include a conviction of an offense which if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon.

(d) Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.

(e) Advertising which is false or misleading, which violates any rule of the board, or which claims without substantiation the positive cure of any disease, or professional superiority to or greater skill than that possessed by another physician.

(f) Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine, or in part regulates the practice of medicine including without limitation sections 604.201, 609.344, and 609.345, or a state or federal narcotics or controlled substance law.

(g) Engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(h) Failure to supervise a physician assistant or failure to supervise a physician under any agreement with the board.

(i) Aiding or abetting an unlicensed person in the practice of medicine, except that it is not a violation of this paragraph for a physician to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of that person's license or registration or delegated authority.

(j) Adjudication as mentally incompetent, mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise.

(k) Engaging in unprofessional conduct. Unprofessional conduct shall include any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice in which proceeding actual injury to a patient need not be established.

(l) Inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills.

(m) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(n) Failure by a doctor of osteopathy to identify the school of healing in the professional use of the doctor's name by one of the following terms: osteopathic physician and surgeon, doctor of osteopathy, or D.O.

(o) Improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to sections 144.291 to 144.298 or to furnish a medical record or report required by law.

(p) Fee splitting, including without limitation:

(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;

(2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;

(3) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the referring physician has a "financial or economic interest," as defined in section 144.6521, subdivision 3, unless the physician has disclosed the physician's financial or economic interest in accordance with section 144.6521; and

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest.

The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

(q) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(r) Becoming addicted or habituated to a drug or intoxicant.

(s) Prescribing a drug or device for other than medically accepted therapeutic or experimental or investigative purposes authorized by a state or federal agency or referring a patient to any health care provider as defined in sections 144.291 to 144.298 for services or tests not medically indicated at the time of referral.

(t) Engaging in conduct with a patient which is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.

(u) Failure to make reports as required by section 147.111 or to cooperate with an investigation of the board as required by section 147.131.

(v) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.

(w) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(1) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(2) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(3) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(4) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

(x) Practice of a board-regulated profession under lapsed or nonrenewed credentials.

~~(y) Failure to repay a state or federally secured student loan in accordance with the provisions of the loan.~~

~~(z)~~ (y) Providing interstate telemedicine services other than according to section 147.032.

Sec. 8. Minnesota Statutes 2014, section 148.271, is amended to read:

148.271 EXEMPTIONS.

The provisions of sections 148.171 to 148.285 shall not prohibit:

(1) The furnishing of nursing assistance in an emergency.

(2) The practice of advanced practice, professional, or practical nursing by any legally qualified advanced practice, registered, or licensed practical nurse of another state who is employed by the United States government or any bureau, division, or agency thereof while in the discharge of official duties.

(3) The practice of any profession or occupation licensed by the state, other than advanced practice, professional, or practical nursing, by any person duly licensed to practice the profession or occupation, or the performance by a person of any acts properly coming within the scope of the profession, occupation, or license.

(4) The provision of a nursing or nursing-related service by an unlicensed assistive person who has been delegated or assigned the specific function and is supervised by a registered nurse or monitored by a licensed practical nurse.

(5) The care of the sick with or without compensation when done in a nursing home covered by the provisions of section 144A.09, subdivision 1.

(6) Professional nursing practice or advanced practice registered nursing practice by a registered nurse or practical nursing practice by a licensed practical nurse licensed in another state or territory who is in Minnesota as a student enrolled in a formal, structured course of study, such as a course leading to a higher degree, certification in a nursing specialty, or to enhance skills in a clinical field, while the student is practicing in the course.

(7) Professional or practical nursing practice by a student practicing under the supervision of an instructor while the student is enrolled in a nursing program approved by the board under section 148.251.

(8) Advanced practice registered nursing as defined in section 148.171, subdivisions 5, 10, 11, 13, and 21, by a registered nurse who is licensed and currently registered in Minnesota or another United States jurisdiction and who is enrolled as a student in a formal graduate education program leading to eligibility for certification and licensure as an advanced practice registered nurse.

(9) Professional nursing practice or advanced practice registered nursing practice by a registered nurse or advanced practice registered nurse licensed in another state, territory, or jurisdiction who is in Minnesota temporarily:

(i) providing continuing or in-service education;

(ii) serving as a guest lecturer;

(iii) presenting at a conference; or

(iv) teaching didactic content via distance education to a student located in Minnesota who is enrolled in a formal, structured course of study, such as a course leading to a higher degree or certification in a nursing specialty.

Sec. 9. Minnesota Statutes 2014, section 148.52, is amended to read:

148.52 BOARD OF OPTOMETRY.

The Board of Optometry shall consist of two public members as defined by section 214.02 and five ~~qualified~~ Minnesota licensed optometrists appointed by the governor. Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements shall be as provided in sections 214.07 to 214.09.

The provision of staff, administrative services and office space; the review and processing of complaints; the setting of board fees; and other provisions relating to board operations shall be as provided in chapter 214.

Sec. 10. Minnesota Statutes 2014, section 148.54, is amended to read:

148.54 BOARD; SEAL.

The Board of Optometry shall elect from among its members a president, vice president, and secretary and may adopt a seal.

Sec. 11. Minnesota Statutes 2014, section 148.57, subdivision 1, is amended to read:

Subdivision 1. **Examination.** (a) A person not authorized to practice optometry in the state and desiring to do so shall apply to the state Board of Optometry by filling out and swearing to an application for a license granted by the board and accompanied by a fee ~~in an amount of $87~~ established by the board, not to exceed the amount specified in

section 148.59. With the submission of the application form, the candidate shall prove that the candidate:

(1) is of good moral character;

(2) has obtained a clinical doctorate degree from a board-approved school or college of optometry, or is currently enrolled in the final year of study at such an institution; and

(3) has passed all parts of an examination.

(b) The examination shall include both a written portion and a clinical practical portion and shall thoroughly test the fitness of the candidate to practice in this state. In regard to the written and clinical practical examinations, the board may:

(1) prepare, administer, and grade the examination itself;

(2) recognize and approve in whole or in part an examination prepared, administered and graded by a national board of examiners in optometry; or

(3) administer a recognized and approved examination prepared and graded by or under the direction of a national board of examiners in optometry.

(c) The board shall issue a license to each applicant who satisfactorily passes the examinations and fulfills the other requirements stated in this section ~~and section 148.575 for board certification for the use of legend drugs. Applicants for initial licensure do not need to apply for or possess a certificate as referred to in sections 148.571 to 148.574. The fees mentioned in this section are for the use of the board and in no case shall be refunded~~.

Sec. 12. Minnesota Statutes 2014, section 148.57, subdivision 2, is amended to read:

Subd. 2. **Endorsement.** (a) An optometrist who holds a current license from another state, and who has practiced in that state not less than three years immediately preceding application, may apply for licensure in Minnesota by filling out and swearing to an application for license by endorsement furnished by the board. The completed application with all required documentation shall be filed at the board office along with a fee ~~of $87~~ established by the board, not to exceed the amount specified in section 148.59. The application fee shall be for the use of the board and in no case shall be refunded.

(b) To verify that the applicant possesses the knowledge and ability essential to the practice of optometry in this state, the applicant must provide evidence of:

(1) having obtained a clinical doctorate degree from a board-approved school or college of optometry;

(2) successful completion of both written and practical examinations for licensure in the applicant's original state of licensure that thoroughly tested the fitness of the applicant to practice;

(3) successful completion of an examination of Minnesota state optometry laws;

(4) compliance with the requirements ~~for board certification~~ in section 148.575;

(5) compliance with all continuing education required for license renewal in every state in which the applicant currently holds an active license to practice; and

(6) being in good standing with every state board from which a license has been issued.

(c) Documentation from a national certification system or program, approved by the board, which supports any of the listed requirements, may be used as evidence. The applicant may then be issued a license if the requirements for licensure in the other state are deemed by the board to be equivalent to those of sections 148.52 to 148.62.

Sec. 13. Minnesota Statutes 2014, section 148.57, is amended by adding a subdivision to read:

Subd. 5. **Change of address.** A person regulated by the board shall maintain a current name and address with the board and shall notify the board in writing within 30 days of any change in name or address. If a name change only is requested, the regulated person must request revised credentials and return the current credentials to the board. The board may require the regulated person to substantiate the name change by submitting official documentation from a court of law or agency authorized under law to receive and officially record a name change. If an address change only is requested, no request for revised credentials is required. If the regulated person's current credentials have been lost, stolen, or destroyed, the person shall provide a written explanation to the board.

Sec. 14. Minnesota Statutes 2014, section 148.574, is amended to read:

148.574 PROHIBITIONS RELATING TO LEGEND DRUGS; ~~AUTHORIZING SALES BY PHARMACISTS UNDER CERTAIN CONDITIONS.~~

~~An optometrist shall not purchase, possess, administer, prescribe or give any legend drug as defined in section 151.01 or 152.02 to any person except as is expressly authorized by sections 148.571 to 148.577. Nothing in chapter 151 shall prevent a pharmacist from selling topical ocular drugs to an optometrist authorized to use such drugs according to sections 148.571 to 148.577.~~ Notwithstanding sections 151.37 and 152.12, an optometrist is prohibited from dispensing legend drugs at retail, unless the legend drug is within the scope designated in section 148.56, subdivision 1, and is administered to the eye through an ophthalmic good as defined in section 145.711, subdivision 4.

Sec. 15. Minnesota Statutes 2014, section 148.575, subdivision 2, is amended to read:

Subd. 2. **~~Board certified~~ Requirements defined.** ~~"Board certified" means that~~ A licensed optometrist ~~has been issued a certificate by the Board of Optometry certifying that the optometrist has complied~~ shall comply with the following requirements for the use of legend drugs ~~described in section 148.576~~:

~~(1) successful completion of at least 60 hours of study in general and ocular pharmacology emphasizing drugs used for examination or treatment purposes, their systemic effects and management or referral of adverse reactions;~~

~~(2)~~ (1) successful completion of at least 100 hours of study in the examination, diagnosis, and treatment of conditions of the human eye with legend drugs;

~~(3)~~ (2) successful completion of two years of supervised clinical experience in differential diagnosis of eye disease or disorders as part of optometric training or one year of that experience and ten years of actual clinical experience as a licensed optometrist; and

~~(4)~~ (3) successful completion of a nationally standardized examination approved or administered by the board on the subject of treatment and management of ocular disease.

Sec. 16. Minnesota Statutes 2014, section 148.577, is amended to read:

148.577 STANDARD OF CARE.

A licensed optometrist ~~who is board certified under section 148.575~~ is held to the same standard of care in the use of those legend drugs as physicians licensed by the state of Minnesota.

Sec. 17. Minnesota Statutes 2014, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; ~~FEE~~ LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, $135;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; and

(9) license verification, $50.

Sec. 18. Minnesota Statutes 2014, section 148.603, is amended to read:

148.603 ~~FORMS OF~~ GROUNDS FOR DISCIPLINARY ~~ACTIONS~~ ACTION.

~~When grounds exist under section 148.57, subdivision 3, or other statute or rule which the board is authorized to enforce, the board may take one or more of the following disciplinary actions, provided that disciplinary or corrective action may not be imposed by the board on any regulated person except after a contested case hearing conducted pursuant to chapter 14 or by consent of the parties:~~

~~(1) deny an application for a credential;~~

~~(2) revoke the regulated person's credential;~~

~~(3) suspend the regulated person's credential;~~

~~(4) impose limitations on the regulated person's credential;~~

~~(5) impose conditions on the regulated person's credential;~~

~~(6) censure or reprimand the regulated person;~~

~~(7) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the person of any economic advantage gained by reason of the violation or to discourage similar violations or to reimburse the board for the cost of the investigation and proceeding. For purposes of this section, the cost of the investigation and proceeding may include, but is not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; or~~

~~(8) when grounds exist under section 148.57, subdivision 3, or a board rule, enter into an agreement with the regulated person for corrective action which may include requiring the regulated person:~~

~~(i) to complete an educational course or activity;~~

~~(ii) to submit to the executive director or designated board member a written protocol or reports designed to prevent future violations of the same kind;~~

~~(iii) to meet with a board member or board designee to discuss prevention of future violations of the same kind; or~~

~~(iv) to perform other action justified by the facts.~~

~~Listing the measures in clause (8) does not preclude the board from including them in an order for disciplinary action.~~ The board may refuse to grant a license or may impose disciplinary action as described in section 148.607 against any optometrist for the following:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or in rules of the board. The burden of proof shall be on the applicant to demonstrate the qualifications or the satisfaction of the requirements;

(2) obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process. Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) conviction, during the previous five years, of a felony or gross misdemeanor, reasonably related to the practice of optometry. Conviction as used in this section shall include a conviction of an offense which if committed in this state would be deemed a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon;

(4) revocation, suspension, restriction, limitation, or other disciplinary action against the person's optometry license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction;

(5) advertising which is false or misleading, which violates any rule of the board, or which claims without substantiation the positive cure of any disease;

(6) violating a rule adopted by the board or an order of the board, a state or federal law, which relates to the practice of optometry, or a state or federal narcotics or controlled substance law;

(7) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or practice of optometry which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, which in any of the cases, proof of actual injury need not be established;

(8) failure to supervise an optometrist's assistant or failure to supervise an optometrist under any agreement with the board;

(9) aiding or abetting an unlicensed person in the practice of optometry, except that it is not a violation of this section for an optometrist to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of that person's license or registration or delegated authority;

(10) adjudication as mentally incompetent, mentally ill, or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerous person, or a person who has a sexual psychopathic personality by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration of the license unless the board orders otherwise;

(11) engaging in unprofessional conduct which includes any departure from or the failure to conform to the minimal standards of acceptable and prevailing practice in which case actual injury to a patient need not be established;

(12) inability to practice optometry with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(13) revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(14) improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to sections 144.291 to 144.298 or to furnish a medical record or report required by law;

(15) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices; and

(ii) dividing fees with another optometrist, other health care provider, or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the optometrist has disclosed the terms of the division;

(16) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws;

(17) becoming addicted or habituated to a drug or intoxicant;

(18) prescribing a drug or device for other than accepted therapeutic or experimental or investigative purposes authorized by the state or a federal agency;

(19) engaging in conduct with a patient which is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 148.604 or to cooperate with an investigation of the board as required by section 148.606;

(21) knowingly providing false or misleading information that is directly related to the care of a patient; and

(22) practice of a board-regulated profession under lapsed or nonrenewed credentials.

Sec. 19. **[148.604] REPORTING OBLIGATIONS.**

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct constituting grounds for discipline under sections 148.52 to 148.62 may report the violation to the board.

Subd. 2. **Institutions.** Any hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state shall report to the board any action taken by the institution or organization or any of its administrators or medical or other committees to revoke, suspend, restrict, or condition an optometrist's privilege to practice or treat patients in the institution, or as part of the organization, any denial of privileges, or any other disciplinary action. The institution or organization shall also report the resignation of any optometrist prior to the conclusion of any disciplinary proceeding, or prior to the commencement of formal charges but after the optometrist had knowledge that formal charges were contemplated or in preparation. Each report made under this subdivision must state the nature of the action taken, state in detail the reasons for the action, and identify the specific patient medical records upon which the action was based. No report shall be required of an optometrist voluntarily limiting the practice of the optometrist at a hospital provided that the optometrist notifies all hospitals where the optometrist has privileges of the voluntary limitation and the reasons for it.

Subd. 3. **Licensed professionals.** A licensed optometrist shall report to the board personal knowledge of any conduct by any optometrist which the person reasonably believes constitutes grounds for disciplinary action under sections 148.52 to 148.62, including any conduct indicating that the person may be incompetent, may have engaged in unprofessional conduct, or may be physically unable to safely engage in the practice of optometry.

Subd. 4. **Self-reporting.** An optometrist shall report to the board any personal action which would require that a report be filed with the board by any person, health care facility, business, or organization pursuant to subdivisions 2 and 3.

Subd. 5. **Deadlines; forms; rulemaking.** Reports required by subdivisions 2 to 4 must be submitted not later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that reports be submitted on the forms provided, and may adopt rules necessary to ensure prompt and accurate reporting.

Subd. 6. **Subpoenas.** The board may issue subpoenas for the production of any reports required by subdivisions 2 to 4 or any related documents.

Sec. 20. **[148.605] IMMUNITY.**

Subdivision 1. **Reporting.** Any person, health care facility, business, or organization is immune from civil liability or criminal prosecution for submitting a report to the board pursuant to section 148.604 or for otherwise reporting to the board violations or alleged violations of section 148.603, if they are acting in good faith and in the exercise of reasonable care.

Subd. 2. **Investigation; indemnification.** (a) Members of the board, persons employed by the board, and consultants retained by the board for the purpose of investigation of violations, the preparation of charges, and management of board orders on behalf of the board are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under sections 148.52 to 148.62, if they are acting in good faith and in the exercise of reasonable care.

(b) Members of the board and persons employed by the board or engaged in maintaining records and making reports regarding adverse health care events are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under sections 148.52 to 148.62, if they are acting in good faith and in the exercise of reasonable care.

(c) For purposes of this section, a member of the board or a consultant described in paragraph (a) is considered a state employee under section 3.736, subdivision 9.

Sec. 21. **[148.606] OPTOMETRIST COOPERATION.**

An optometrist who is the subject of an investigation by or on behalf of the board shall cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation and providing copies of patient medical records, as reasonably requested by the board, to assist the board in its investigation. If the board does not have written consent from a patient permitting access to the patient's records, the optometrist shall delete any data in the record which identifies the patient before providing it to the board.

The board shall maintain any records obtained pursuant to this section as investigative data pursuant to chapter 13.

Sec. 22. **[148.607] DISCIPLINARY ACTIONS.**

When the board finds that a licensed optometrist under section 148.57 has violated a provision or provisions of sections 148.52 to 148.62, it may do one or more of the following:

(1) revoke the license;

(2) suspend the license;

(3) impose limitations or conditions on the optometrist's practice of optometry, including the limitation of scope of practice to designated field specialties; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(4) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the optometrist of any economic advantage gained by reason of the violation charged or to reimburse the board for the cost of the investigation and proceeding; and

(5) censure or reprimand the licensed optometrist.

Sec. 23. Minnesota Statutes 2014, section 148E.075, is amended to read:

148E.075 ~~INACTIVE LICENSES~~ ALTERNATE LICENSES.

Subdivision 1. ~~**Inactive status**~~ **Temporary leave license.** (a) ~~A licensee qualifies for inactive status under either of the circumstances described in paragraph (b) or (c).~~

~~(b) A licensee qualifies for inactive status when the licensee is granted temporary leave from active practice.~~ A licensee qualifies for temporary leave from active practice if the licensee demonstrates to the satisfaction of the board that the licensee is not engaged in the practice of social work in any setting, including settings in which social workers are exempt from licensure according to section 148E.065. A licensee who is granted temporary leave from active practice may reactivate the license according to section 148E.080.

(b) A licensee may maintain a temporary leave license for no more than four consecutive years.

~~(c) A licensee qualifies for inactive status when a licensee is granted an emeritus license. A licensee qualifies for an emeritus license if the licensee demonstrates to the satisfaction of the board that:~~

~~(1) the licensee is retired from social work practice; and~~

~~(2) the licensee is not engaged in the practice of social work in any setting, including settings in which social workers are exempt from licensure according to section 148E.065.~~

~~A licensee who possesses an emeritus license may reactivate the license according to section 148E.080.~~

(c) A licensee who is granted temporary leave from active practice may reactivate the license according to section 148E.080. If a licensee does not apply for reactivation within 60 days following the end of the consecutive four-year period, the license automatically expires. An individual with an expired license may apply for new licensure according to section 148E.055.

(d) Except as provided in paragraph (e), a licensee who holds a temporary leave license must not practice, attempt to practice, offer to practice, or advertise or hold out as authorized to practice social work.

(e) The board may grant a variance to the requirements of paragraph (d) if a licensee on temporary leave license provides emergency social work services. A variance is granted only if the board provides the variance in writing to the licensee. The board may impose conditions or restrictions on the variance.

(f) In making representations of professional status to the public, when holding a temporary leave license, a licensee must state that the license is not active and that the licensee cannot practice social work.

Subd. 1a. **Emeritus inactive license.** (a) A licensee qualifies for an emeritus inactive license if the licensee demonstrates to the satisfaction of the board that the licensee is:

(1) retired from social work practice; and

(2) not engaged in the practice of social work in any setting, including settings in which social workers are exempt from licensure according to section 148E.065.

(b) A licensee with an emeritus inactive license may apply for reactivation according to section 148E.080 only during the four years following the granting of the emeritus inactive license. However, after four years following the granting of the emeritus inactive license, an individual may apply for new licensure according to section 148E.055.

(c) Except as provided in paragraph (d), a licensee who holds an emeritus inactive license must not practice, attempt to practice, offer to practice, or advertise or hold out as authorized to practice social work.

(d) The board may grant a variance to the requirements of paragraph (c) if a licensee on emeritus inactive license provides emergency social work services. A variance is granted only if the board provides the variance in writing to the licensee. The board may impose conditions or restrictions on the variance.

(e) In making representations of professional status to the public, when holding an emeritus inactive license, a licensee must state that the license is not active and that the licensee cannot practice social work.

Subd. 1b. **Emeritus active license.** (a) A licensee qualifies for an emeritus active license if the applicant demonstrates to the satisfaction of the board that the licensee is:

(1) retired from social work practice; and

(2) in compliance with the supervised practice requirements, as applicable, under sections 148E.100 to 148E.125.

(b) A licensee who is issued an emeritus active license is only authorized to engage in:

(1) pro bono or unpaid social work practice as specified in section 148E.010, subdivisions 6 and 11; or

(2) paid social work practice not to exceed 240 clock hours per calendar year, for the exclusive purpose to provide licensing supervision as specified in sections 148E.100 to 148E.125; and

(3) the authorized scope of practice specified in section 148E.050.

(c) An emeritus active license must be renewed according to the requirements specified in section 148E.070, subdivisions 1, 2, 3, 4, and 5.

(d) At the time of license renewal a licensee must provide evidence satisfactory to the board that the licensee has, during the renewal term, completed 20 clock hours of continuing education, including at least two clock hours in ethics, as specified in section 148E.130:

(1) for licensed independent clinical social workers, at least 12 clock hours must be in the clinical content areas specified in section 148E.055, subdivision 5; and

(2) for social workers providing supervision according to sections 148E.100 to 148E.125, at least three clock hours must be in the practice of supervision.

(e) Independent study hours must not consist of more than eight clock hours of continuing education per renewal term.

(f) Failure to renew an active emeritus license on the expiration date will result in an expired license as specified in section 148E.070, subdivision 5.

(g) The board may grant a variance to the requirements of paragraph (b) if a licensee holding an emeritus active license provides emergency social work services. A variance is granted only if the board provides the variance in writing to the licensee. The board may impose conditions or restrictions on the variance.

(h) In making representations of professional status to the public, when holding an emeritus active license, a licensee must state that an emeritus active license authorizes only pro bono or unpaid social work practice, or paid social work practice not to exceed 240

clock hours per calendar year, for the exclusive purpose to provide licensing supervision as specified in sections 148E.100 to 148E.125.

(i) Notwithstanding the time limit and emeritus active license renewal requirements specified in this section, a licensee who possesses an emeritus active license may reactivate the license according to section 148E.080 or apply for new licensure according to section 148E.055.

Subd. 2. **Application.** A licensee may apply for ~~inactive status~~ temporary leave license, emeritus inactive license, or emeritus active license:

(1) at any time when currently licensed under section 148E.055, 148E.0555, 148E.0556, or 148E.0557, or when licensed as specified in section 148E.075, by submitting an application ~~for a temporary leave from active practice or for an emeritus license~~ form required by the board; or

(2) as an alternative to applying for the renewal of a license by so recording on the application ~~for license renewal~~ form required by the board and submitting the completed, signed application to the board.

An application that is not completed or signed, or that is not accompanied by the correct fee, must be returned to the applicant, along with any fee submitted, and is void. For applications submitted electronically, a "signed application" means providing an attestation as specified by the board.

Subd. 3. **Fee.** (a) Regardless of when the application for ~~inactive status~~ temporary leave license or emeritus inactive license is submitted, the temporary leave license or emeritus inactive license fee specified in section 148E.180, whichever is applicable, must accompany the application. A licensee who is approved for ~~inactive status~~ temporary leave license or emeritus inactive license before the license expiration date is not entitled to receive a refund for any portion of the license or renewal fee.

(b) If an application for temporary leave or emeritus active license is received after the license expiration date, the licensee must pay a renewal late fee as specified in section 148E.180 in addition to the temporary leave fee.

(c) Regardless of when the application for emeritus active license is submitted, the emeritus active license fee is one-half of the renewal fee for the applicable license specified in section 148E.180, subdivision 3, and must accompany the application. A licensee who is approved for emeritus active license before the license expiration date is not entitled to receive a refund for any portion of the license or renewal fee.

~~Subd. 4. **Time limits for temporary leaves.** A licensee may maintain an inactive license on temporary leave for no more than five consecutive years. If a licensee does~~

~~not apply for reactivation within 60 days following the end of the consecutive five-year period, the license automatically expires.~~

~~Subd. 5. **Time limits for emeritus license.** A licensee with an emeritus license may not apply for reactivation according to section 148E.080 after five years following the granting of the emeritus license. However, after five years following the granting of the emeritus license, an individual may apply for new licensure according to section 148E.055.~~

~~Subd. 6. **Prohibition on practice.** (a) Except as provided in paragraph (b), a licensee whose license is inactive must not practice, attempt to practice, offer to practice, or advertise or hold out as authorized to practice social work.~~

~~(b) The board may grant a variance to the requirements of paragraph (a) if a licensee on inactive status provides emergency social work services. A variance is granted only if the board provides the variance in writing to the licensee. The board may impose conditions or restrictions on the variance.~~

~~Subd. 7. **Representations of professional status.** In making representations of professional status to the public, a licensee whose license is inactive must state that the license is inactive and that the licensee cannot practice social work.~~

Subd. 8. **Disciplinary or other action.** The board may resolve any pending complaints against a licensee before approving an application for ~~inactive status~~ an alternate license specified in this section. The board may take action according to sections 148E.255 to 148E.270 against a licensee ~~whose license is inactive~~ who is issued an alternate license specified in this section based on conduct occurring before the license is inactive or conduct occurring while the license is ~~inactive~~ effective.

Sec. 24. Minnesota Statutes 2014, section 148E.080, subdivision 1, is amended to read:

Subdivision 1. **Mailing notices to licensees on temporary leave.** The board must mail a notice for reactivation to a licensee on temporary leave at least 45 days before the expiration date of the license according to section 148E.075, subdivision ~~4~~ 1. Mailing the notice by United States mail to the licensee's last known mailing address constitutes valid mailing. Failure to receive the reactivation notice does not relieve a licensee of the obligation to comply with the provisions of this section to reactivate a license.

Sec. 25. Minnesota Statutes 2014, section 148E.080, subdivision 2, is amended to read:

Subd. 2. **Reactivation from a temporary leave or emeritus status.** To reactivate a license from a temporary leave or emeritus status, a licensee must do the following within the time period specified in section 148E.075, subdivisions ~~4 and 5~~ 1, 1a, and 1b:

(1) complete an application form specified by the board;

(2) document compliance with the continuing education requirements specified in subdivision 4;

(3) submit a supervision plan, if required;

(4) pay the reactivation of ~~an inactive licensee~~ a license fee specified in section 148E.180; and

(5) pay the wall certificate fee according to section 148E.095, subdivision 1, paragraph (b) or (c), if the licensee needs a duplicate license.

Sec. 26. Minnesota Statutes 2014, section 148E.180, subdivision 2, is amended to read:

Subd. 2. **License fees.** License fees are as follows:

(1) for a licensed social worker, $81;

(2) for a licensed graduate social worker, $144;

(3) for a licensed independent social worker, $216;

(4) for a licensed independent clinical social worker, $238.50;

(5) for an emeritus inactive license, $43.20; ~~and~~

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Sec. 27. Minnesota Statutes 2014, section 148E.180, subdivision 5, is amended to read:

Subd. 5. **Late fees.** Late fees are as follows:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3; ~~and~~

(2) supervision plan late fee, $40~~.~~; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Sec. 28. Minnesota Statutes 2014, section 150A.091, subdivision 4, is amended to read:

Subd. 4. **Annual license fees.** Each limited faculty or resident dentist shall submit with an annual license renewal application a fee established by the board not to exceed the following amounts:

(1) limited faculty dentist, $168; and

(2) resident dentist or dental provider, ~~$59~~ $85.

Sec. 29. Minnesota Statutes 2014, section 150A.091, subdivision 5, is amended to read:

Subd. 5. **Biennial license or permit fees.** Each of the following applicants shall submit with a biennial license or permit renewal application a fee as established by the board, not to exceed the following amounts:

(1) dentist or full faculty dentist, ~~$336~~ $475;

(2) dental therapist, ~~$180~~ $300;

(3) dental hygienist, ~~$118~~ $200;

(4) licensed dental assistant, ~~$80~~ $150; and

(5) dental assistant with a permit as described in Minnesota Rules, part 3100.8500, subpart 3, $24.

Sec. 30. Minnesota Statutes 2014, section 150A.091, subdivision 11, is amended to read:

Subd. 11. **Certificate application fee for anesthesia/sedation.** Each dentist shall submit with a general anesthesia or moderate sedation application ~~or~~, a contracted sedation provider application, or biennial renewal, a fee as established by the board not to exceed the following amounts:

(1) for both a general anesthesia and moderate sedation application, ~~$250~~ $400;

(2) for a general anesthesia application only, ~~$250~~ $400;

(3) for a moderate sedation application only, ~~$250~~ $400; and

(4) for a contracted sedation provider application, ~~$250~~ $400.

Sec. 31. Minnesota Statutes 2014, section 150A.091, is amended by adding a subdivision to read:

Subd. 17. **Advanced dental therapy examination fee.** Any dental therapist eligible to sit for the advanced dental therapy certification examination must submit with the application a fee as established by the board, not to exceed $250.

Sec. 32. Minnesota Statutes 2014, section 150A.091, is amended by adding a subdivision to read:

Subd. 18. **Corporation or professional firm late fee.** Any corporation or professional firm whose annual fee is not postmarked or otherwise received by the board by the due date of December 31 shall, in addition to the fee, submit a late fee as established by the board, not to exceed $15.

Sec. 33. Minnesota Statutes 2014, section 150A.31, is amended to read:

150A.31 FEES.

(a) The initial biennial registration fee is $50.

(b) The biennial renewal registration fee is ~~$25~~ not to exceed $80.

(c) The fees specified in this section are nonrefundable and shall be deposited in the state government special revenue fund.

Sec. 34. Minnesota Statutes 2014, section 151.01, subdivision 15a, is amended to read:

Subd. 15a. **Pharmacy technician.** "Pharmacy technician" means a person not licensed as a pharmacist or registered as a pharmacist intern, who ~~assists the pharmacist in the preparation and dispensing of medications by performing computer entry of prescription data and other manipulative tasks. A pharmacy technician shall not perform tasks specifically reserved to a licensed pharmacist or requiring~~ has been trained in pharmacy tasks that do not require the professional judgment of a licensed pharmacist. A pharmacy technician may not perform tasks specifically reserved to a licensed pharmacist.

Sec. 35. Minnesota Statutes 2014, section 151.01, subdivision 27, is amended to read:

Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

(1) interpretation and evaluation of prescription drug orders;

(2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);

(3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;

(4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; drug regimen reviews; and drug or drug-related research;

(5) participation in administration of influenza vaccines to all eligible individuals ~~ten~~ six years of age and older and all other vaccines to patients ~~18~~ 13 years of age and older by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:

(i) the protocol includes, at a minimum:

(A) the name, dose, and route of each vaccine that may be given;

(B) the patient population for whom the vaccine may be given;

(C) contraindications and precautions to the vaccine;

(D) the procedure for handling an adverse reaction;

(E) the name, signature, and address of the physician, physician assistant, or advanced practice registered nurse;

(F) a telephone number at which the physician, physician assistant, or advanced practice registered nurse can be contacted; and

(G) the date and time period for which the protocol is valid;

(ii) the pharmacist has successfully completed a program approved by the Accreditation Council for Pharmacy Education specifically for the administration of immunizations or a program approved by the board;

(iii) the pharmacist utilizes the Minnesota Immunization Information Connection to assess the immunization status of individuals prior to the administration of vaccines, except when administering influenza vaccines to individuals age nine and older;

(iv) the pharmacist reports the administration of the immunization ~~to the patient's primary physician or clinic or~~ to the Minnesota Immunization Information Connection; and

~~(iv)~~ (v) the pharmacist complies with guidelines for vaccines and immunizations established by the federal Advisory Committee on Immunization Practices, except that a pharmacist does not need to comply with those portions of the guidelines that establish immunization schedules when administering a vaccine pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice nurse authorized to prescribe drugs under section 148.235, provided that the order is consistent with the United States Food and Drug Administration approved labeling of the vaccine;

(6) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;

(7) participation in the storage of drugs and the maintenance of records;

(8) patient counseling on therapeutic values, content, hazards, and uses of drugs and devices; and

(9) offering or performing those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of a pharmacy.

Sec. 36. Minnesota Statutes 2014, section 151.02, is amended to read:

151.02 STATE BOARD OF PHARMACY.

The Minnesota State Board of Pharmacy shall consist of ~~two~~ three public members as defined by section 214.02 and ~~five~~ six pharmacists actively engaged in the practice of pharmacy in this state. Each of said pharmacists shall have had at least five consecutive years of practical experience as a pharmacist immediately preceding appointment.

Sec. 37. Minnesota Statutes 2014, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$130~~ $145;

(2) pharmacist licensed by reciprocity, ~~$225~~ $240;

(3) pharmacy intern, ~~$30~~ $37.50;

(4) pharmacy technician, ~~$30~~ $37.50;

(5) pharmacy, ~~$190~~ $225;

(6) drug wholesaler, legend drugs only, ~~$200~~ $235;

(7) drug wholesaler, legend and nonlegend drugs, ~~$200~~ $235;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$175~~ $210;

(9) drug wholesaler, medical gases, ~~$150~~ $175;

(10) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(11) drug manufacturer, legend drugs only, ~~$200~~ $235;

(12) drug manufacturer, legend and nonlegend drugs, ~~$200~~ $235;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$175~~ $210;

(14) drug manufacturer, medical gases, ~~$150~~ $185;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(16) medical gas distributor, ~~$75~~ $110;

(17) controlled substance researcher, ~~$50~~ $75; and

(18) pharmacy professional corporation, ~~$100~~ $125.

Sec. 38. Minnesota Statutes 2014, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$130~~ $145.

Sec. 39. Minnesota Statutes 2014, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$130~~ $145;

(2) pharmacy technician, ~~$30~~ $37.50;

(3) pharmacy, ~~$190~~ $225;

(4) drug wholesaler, legend drugs only, ~~$200~~ $235;

(5) drug wholesaler, legend and nonlegend drugs, ~~$200~~ $235;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$175~~ $210;

(7) drug wholesaler, medical gases, ~~$150~~ $185;

(8) drug wholesaler, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(9) drug manufacturer, legend drugs only, ~~$200~~ $235;

(10) drug manufacturer, legend and nonlegend drugs, ~~$200~~ $235;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$175~~ $210;

(12) drug manufacturer, medical gases, ~~$150~~ $185;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$125~~ $150;

(14) medical gas distributor, ~~$75~~ $110;

(15) controlled substance researcher, ~~$50~~ $75; and

(16) pharmacy professional corporation, ~~$45~~ $75.

Sec. 40. Minnesota Statutes 2014, section 151.065, subdivision 4, is amended to read:

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, ~~$15~~ $20;

(2) duplicate small license, ~~$15~~ $20; and

(3) duplicate large certificate, ~~$25~~ $30.

Sec. 41. Minnesota Statutes 2014, section 151.102, is amended to read:

151.102 PHARMACY TECHNICIAN.

Subdivision 1. **General.** A pharmacy technician may assist a pharmacist in the practice of pharmacy by performing ~~nonjudgmental~~ tasks ~~and~~ that are not reserved to, and do not require the professional judgment of, a licensed pharmacist. A pharmacy technician works under the personal and direct supervision of the pharmacist. A pharmacist may supervise ~~two~~ up to three technicians~~, as long as the~~. A pharmacist ~~assumes responsibility~~ is responsible for all the ~~functions~~ work performed by the technicians who are under the supervision of the pharmacist. A pharmacy may exceed the ratio of pharmacy technicians to pharmacists permitted in this subdivision or in rule by a total of one technician at

any given time in the pharmacy, provided at least one technician in the pharmacy holds a valid certification from the Pharmacy Technician Certification Board or from another national certification body for pharmacy technicians that requires passage of a nationally recognized, psychometrically valid certification examination for certification as determined by the Board of Pharmacy. The Board of Pharmacy may, by rule, set ratios of technicians to pharmacists greater than ~~two~~ three to one for the functions specified in rule. ~~The delegation of any duties, tasks, or functions by a pharmacist to a pharmacy technician is subject to continuing review and becomes the professional and personal responsibility of the pharmacist who directed the pharmacy technician to perform the duty, task, or function.~~

Subd. 2. **Waivers by board permitted.** A pharmacist in charge in a pharmacy may petition the board for authorization to allow a pharmacist to supervise more than ~~two~~ three pharmacy technicians. The pharmacist's petition must include provisions addressing ~~the maintenance of~~ how patient care and safety will be maintained. A petition filed with the board under this subdivision shall be deemed approved 90 days after the board receives the petition, unless the board denies the petition within 90 days of receipt and notifies the petitioning pharmacist of the petition's denial and the board's reasons for denial.

Subd. 3. **Registration fee.** The board shall not register an individual as a pharmacy technician unless all applicable fees specified in section 151.065 have been paid.

Sec. 42. Minnesota Statutes 2014, section 214.077, is amended to read:

214.077 TEMPORARY LICENSE SUSPENSION; IMMINENT RISK OF SERIOUS HARM.

(a) Notwithstanding any provision of a health-related professional practice act, when a health-related licensing board receives a complaint regarding a regulated person and has probable cause to believe that the regulated person has violated a statute or rule that the health-related licensing board is empowered to enforce, and continued practice by the regulated person presents an imminent risk of serious harm, the health-related licensing board shall issue an order temporarily ~~suspend~~ suspending the regulated person's ~~professional license~~ authority to practice. The temporary suspension order shall ~~take effect upon written notice to the regulated person and shall~~ specify the reason for the suspension~~.~~, including the statute or rule alleged to have been violated. The temporary suspension order shall take effect upon personal service on the regulated person or the regulated person's attorney, or upon the third calendar day after the order is served by first class mail to the most recent address provided to the health-related licensing board for the regulated person or the regulated person's attorney.

(b) The temporary suspension shall remain in effect until the ~~appropriate~~ health-related licensing board ~~or the commissioner~~ completes an investigation, holds a contested case hearing pursuant to the Administrative Procedure Act, and issues a final order in the matter ~~after a hearing~~ as provided for in this section.

(c) At the time it issues the temporary suspension ~~notice~~ order, the ~~appropriate~~ health-related licensing board shall schedule a ~~disciplinary~~ contested case hearing, on the merits of whether discipline is warranted, to be held ~~before the licensing board or~~ pursuant to the Administrative Procedure Act. The regulated person shall be provided with at least ten days' notice of any contested case hearing held pursuant to this section. The contested case hearing shall be scheduled to begin no later than 30 days after ~~issuance~~ the effective service of the temporary suspension order.

(d) The administrative law judge presiding over the contested case hearing shall issue a report and recommendation to the health-related licensing board no later than 30 days after the final day of the contested case hearing. The health-related licensing board shall issue a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations. Except as provided in paragraph (e), if the health-related licensing board has not issued a final order pursuant to sections 14.61 and 14.62 within 30 days of receipt of the administrative law judge's report and recommendations, the temporary suspension shall be lifted.

~~(d)~~ (e) If ~~the board has not completed its investigation and issued a final order within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension shall remain in place until the completion of the investigation.~~ the regulated person requests a delay in the contested case proceedings provided for in paragraphs (c) and (d) for any reason, the temporary suspension shall remain in effect until the health-related licensing board issues a final order pursuant to sections 14.61 and 14.62.

(f) For the purposes of this section, "health-related licensing board" does not include the Office of Unlicensed Complementary and Alternative Health Practices.

Sec. 43. Minnesota Statutes 2014, section 214.10, subdivision 2, is amended to read:

Subd. 2. **Investigation and hearing.** The designee of the attorney general providing legal services to a board shall evaluate the communications forwarded by the board or its members or staff. If the communication alleges a violation of statute or rule which the board is to enforce, the designee is empowered to investigate the facts alleged in the communication. In the process of evaluation and investigation, the designee shall consult with or seek the assistance of the executive director, executive secretary, or, if the board

determines, a member of the board who has been appointed by the board to assist the designee. The designee may also consult with or seek the assistance of any other qualified persons who are not members of the board who the designee believes will materially aid in the process of evaluation or investigation. The executive director, executive secretary, or the consulted board member may attempt to correct improper activities and redress grievances through education, conference, conciliation and persuasion, and in these attempts may be assisted by the designee of the attorney general. If the attempts at correction or redress do not produce satisfactory results in the opinion of the executive director, executive secretary, or the consulted board member, or if after investigation the designee providing legal services to the board, the executive director, executive secretary, or the consulted board member believes that the communication and the investigation suggest illegal or unauthorized activities warranting board action, the person having the belief shall inform the executive director or executive secretary of the board who shall schedule a ~~disciplinary~~ contested case hearing in accordance with chapter 14. Before directing the holding of a ~~disciplinary~~ contested case hearing, the executive director, executive secretary, or the designee of the attorney general shall have considered the recommendations of the consulted board member. Before scheduling a ~~disciplinary~~ contested case hearing, the executive director or executive secretary must have received a verified written complaint from the complaining party. A board member who was consulted during the course of an investigation may participate at the hearing but may not vote on any matter pertaining to the case. The executive director or executive secretary of the board shall promptly inform the complaining party of the final disposition of the complaint. Nothing in this section shall preclude the board from scheduling, on its own motion, a ~~disciplinary~~ contested case hearing based upon the findings or report of the board's executive director or executive secretary, a board member or the designee of the attorney general assigned to the board. Nothing in this section shall preclude a member of the board, executive director, or executive secretary from initiating a complaint.

Sec. 44. Minnesota Statutes 2014, section 214.10, subdivision 2a, is amended to read:

Subd. 2a. **Proceedings.** A board shall initiate proceedings to suspend or revoke a license or shall refuse to renew a license of a person licensed by the board who is convicted in a court of competent jurisdiction of violating section ~~609.224, subdivision 2, paragraph (c)~~ 609.2231, subdivision 8, 609.23, 609.231, 609.2325, 609.233, 609.2335, 609.234, 609.465, 609.466, ~~609.52,~~ or 609.72, subdivision 3.

Sec. 45. Minnesota Statutes 2014, section 214.32, subdivision 6, is amended to read:

Subd. 6. **Duties of a participating board.** Upon receiving a report from the program manager in accordance with section 214.33, subdivision 3, ~~that a regulated person has been discharged from the program due to noncompliance based on allegations that the regulated person has engaged in conduct that might cause risk to the public,~~ ~~when~~ and if the participating health-related licensing board has probable cause to believe continued practice by the regulated person presents an imminent risk of serious harm, the health-related licensing board shall ~~temporarily suspend the regulated person's professional license until the completion of a disciplinary investigation. The board must complete the disciplinary investigation within 30 days of receipt of the report from the program. If the investigation is not completed by the board within 30 days, the temporary suspension shall be lifted, unless the regulated person requests a delay in the disciplinary proceedings for any reason, upon which the temporary suspension shall remain in place until the completion of the investigation~~ proceed pursuant to the requirements in section 214.077.

Sec. 46. **REPEALER.**

Minnesota Statutes 2014, sections 148.57, subdivisions 3 and 4; 148.571; 148.572; 148.573, subdivision 1; 148.575, subdivisions 1, 3, 5, and 6; 148.576; 148E.060, subdivision 12; 148E.075, subdivisions 4, 5, 6, and 7; and 214.105, are repealed.

ARTICLE 12

PUBLIC ASSISTANCE SIMPLIFICATION

Section 1. Minnesota Statutes 2014, section 119B.011, subdivision 15, is amended to read:

Subd. 15. **Income.** "Income" means earned ~~or unearned~~ income ~~received by all family members, including~~ as defined under section 256P.01, subdivision 3, unearned income as defined under section 256P.01, subdivision 8, and public assistance cash benefits ~~and~~, including the Minnesota family investment program, diversionary work program, work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance, at-home infant child care subsidy payments, ~~unless specifically excluded~~ and child support and maintenance distributed to the family under section 256.741, subdivision 15. The following are ~~excluded~~ deducted from income: funds used to pay for health insurance premiums for family members, ~~Supplemental Security Income, scholarships, work-study income, and grants that cover costs or reimbursement for tuition, fees, books, and educational supplies; student loans for tuition, fees, books, supplies, and living expenses; state and federal earned income tax credits; assistance specifically excluded as income by law; in-kind income such as food support, energy assistance, foster care assistance, medical~~

~~assistance, child care assistance, and housing subsidies; earned income of full-time or part-time students up to the age of 19, who have not earned a high school diploma or GED high school equivalency diploma including earnings from summer employment; grant awards under the family subsidy program; nonrecurring lump-sum income only to the extent that it is earmarked and used for the purpose for which it is paid; and any income assigned to the public authority according to section 256.741~~ and child or spousal support paid to or on behalf of a person or persons who live outside of the household. Income sources not included in this subdivision and section 256P.06, subdivision 3, are not counted.

Sec. 2. Minnesota Statutes 2014, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. **Factors which must be verified.** (a) The county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

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

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

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) income;

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

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) If a family did not use the universal application or child care addendum to apply for child care assistance, the family must complete the universal application or child care addendum at its next eligibility redetermination and the county must verify the factors listed in paragraph (a) as part of that redetermination. Once a family has completed a universal application or child care addendum, the county shall use the redetermination form described in paragraph (c) for that family's subsequent redeterminations. Eligibility must be redetermined at least every six months. A family is considered to have met the eligibility redetermination requirement if a complete redetermination form and all required verifications are received within 30 days after the date the form was due. Assistance shall be payable retroactively from the redetermination due date. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or

arranges for child care, as well as parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year. If a family reports a change in an eligibility factor before the family's next regularly scheduled redetermination, the county must recalculate eligibility without requiring verification of any eligibility factor that did not change. Changes must be reported as required by section 256P.07. A change in income occurs on the day the participant received the first payment reflecting the change in income.

(c) The commissioner shall develop a redetermination form to redetermine eligibility and a change report form to report changes that minimize paperwork for the county and the participant.

Sec. 3. Minnesota Statutes 2014, section 119B.035, subdivision 4, is amended to read:

Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of assistance under subdivision 2. The maximum rate of assistance is equal to 68 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence.

(b) A participating family must report income and other family changes as specified in sections 256P.06 and 256P.07, and the county's plan under section 119B.08, subdivision 3.

(c) Persons who are admitted to the at-home infant child care program retain their position in any basic sliding fee program. Persons leaving the at-home infant child care program reenter the basic sliding fee program at the position they would have occupied.

(d) Assistance under this section does not establish an employer-employee relationship between any member of the assisted family and the county or state.

Sec. 4. Minnesota Statutes 2014, section 119B.09, subdivision 4, is amended to read:

Subd. 4. **Eligibility; annual income; calculation.** Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family. Self-employment income must be calculated based on gross receipts less operating expenses. Income must be recalculated when the family's income changes, but no less often than every six months. For a family where at least one parent is under the age of 21, does not have a high school or general equivalency diploma, and is a student in a school district or another similar program that provides or arranges for child care, as well as parenting, social services, career and employment supports, and academic support to

achieve high school graduation, income must be recalculated when the family's income changes, but otherwise shall be deferred beyond six months, but not to exceed 12 months, to the end of the student's school year. Included lump sums counted as income under section 256P.06, subdivision 3, must be annualized over 12 months. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

Sec. 5. Minnesota Statutes 2014, section 256D.01, subdivision 1a, is amended to read:

Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to provide for single adults, childless couples, or children as defined in section 256D.02, subdivision 6, ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The commissioner shall set the standard of assistance for an assistance unit consisting of an adult recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian. When the other standards specified in this subdivision increase, this standard must also be increased by the same percentage.

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance is the amount that the aid to families with dependent children standard of assistance, in effect on July 16, 1996, would increase if the recipient were added as an additional minor child to an assistance unit consisting of the recipient's parent and all of that parent's family members, except that the standard may not exceed the standard for a general assistance recipient living alone. Benefits received by a responsible relative of the assistance unit under the Supplemental Security Income program, a workers' compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the Social Security retirement program, may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods~~, income deductions~~,

~~exclusions, and disregards used when calculating the countable income for a single adult or childless couple~~ must ~~be used~~ follow the provisions under section 256P.06.

(d) For an assistance unit consisting of a childless couple, the standards of assistance are the same as the first and second adult standards of the aid to families with dependent children program in effect on July 16, 1996. If one member of the couple is not included in the general assistance grant, the standard of assistance for the other is the second adult standard of the aid to families with dependent children program as of July 16, 1996.

Sec. 6. Minnesota Statutes 2014, section 256D.02, is amended by adding a subdivision to read:

Subd. 1a. **Assistance unit.** "Assistance unit" means an individual who is, or an eligible married couple who live together who are, applying for or receiving benefits under this chapter.

Sec. 7. Minnesota Statutes 2014, section 256D.02, is amended by adding a subdivision to read:

Subd. 1b. **Cash assistance benefit.** "Cash assistance benefit" means any payment received as a disability benefit, including veterans or workers' compensation; old age, survivors, and disability insurance; railroad retirement benefits; unemployment benefits; and benefits under any federally aided categorical assistance program, Supplemental Security Income, or other assistance program.

Sec. 8. Minnesota Statutes 2014, section 256D.02, subdivision 8, is amended to read:

Subd. 8. **Income.** "Income" means ~~any form of income, including remuneration for services performed as an employee and earned income from rental income and self-employment earnings as described under section 256P.05~~ earned income as defined under section 256P.01, subdivision 3, and unearned income as defined under section 256P.01, subdivision 8.

~~Income includes any payments received as an annuity, retirement, or disability benefit, including veteran's or workers' compensation; old age, survivors, and disability insurance; railroad retirement benefits; unemployment benefits; and benefits under any federally aided categorical assistance program, supplementary security income, or other assistance program; rents, dividends, interest and royalties; and support and maintenance payments. Such payments may not be considered as available to meet the needs of any person other than the person for whose benefit they are received, unless that person is a family member or a spouse and the income is not excluded under section 256D.01,~~

~~subdivision 1a. Goods and services provided in lieu of cash payment shall be excluded from the definition of income, except that payments made for room, board, tuition or fees by a parent, on behalf of a child enrolled as a full-time student in a postsecondary institution, and payments made on behalf of an applicant or participant which the applicant or participant could legally demand to receive personally in cash, must be included as income. Benefits of an applicant or participant, such as those administered by the Social Security Administration, that are paid to a representative payee, and are spent on behalf of the applicant or participant, are considered available income of the applicant or participant.~~

Sec. 9. Minnesota Statutes 2014, section 256D.06, subdivision 1, is amended to read:

Subdivision 1. **Eligibility; amount of assistance.** General assistance shall be granted in an amount that when added to the ~~nonexempt~~ countable income as determined to be actually available to the assistance unit under section 256P.06, the total amount equals the applicable standard of assistance for general assistance. In determining eligibility for and the amount of assistance for an individual or married couple, the agency shall apply the earned income disregard as determined in section 256P.03.

Sec. 10. Minnesota Statutes 2014, section 256D.405, subdivision 3, is amended to read:

Subd. 3. **Reports.** Participants must report changes in circumstances according to section 256P.07 that affect eligibility or assistance payment amounts within ten days of the change. Participants who do not receive SSI because of excess income must complete a monthly report form if they have earned income, if they have income deemed to them from a financially responsible relative with whom the participant resides, or if they have income deemed to them by a sponsor. If the report form is not received before the end of the month in which it is due, the county agency must terminate assistance. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month the assistance was terminated, the assistance unit is considered to have continued its application for assistance, effective the first day of the month the assistance was terminated.

Sec. 11. Minnesota Statutes 2014, section 256I.03, is amended by adding a subdivision to read:

Subd. 1b. **Assistance unit.** "Assistance unit" means an individual who is applying for or receiving benefits under this chapter.

Sec. 12. Minnesota Statutes 2014, section 256I.03, subdivision 7, is amended to read:

Subd. 7. **Countable income.** "Countable income" means all income received by an applicant or recipient as described under section 256P.06, less any applicable exclusions or disregards. For a recipient of any cash benefit from the SSI program, countable income means the SSI benefit limit in effect at the time the person is in a GRH, less the medical assistance personal needs allowance. If the SSI limit has been reduced for a person due to events occurring prior to the persons entering the GRH setting, countable income means actual income less any applicable exclusions and disregards.

Sec. 13. Minnesota Statutes 2014, section 256I.04, subdivision 1, is amended to read:

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

(a) The individual is aged, blind, or is over 18 years of age and disabled as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of group residential housing in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under ~~sections 256D.01 to 256D.21~~ section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of group residential housing in which the individual resides.

Sec. 14. Minnesota Statutes 2014, section 256I.06, subdivision 6, is amended to read:

Subd. 6. **Reports.** Recipients must report changes in circumstances according to section 256P.07 that affect eligibility or group residential housing payment amounts within ten days of the change. Recipients with countable earned income must complete a monthly household report form. If the report form is not received before the end of the month in which it is due, the county agency must terminate eligibility for group residential housing payments. The termination shall be effective on the first day of the

month following the month in which the report was due. If a complete report is received within the month eligibility was terminated, the individual is considered to have continued an application for group residential housing payment effective the first day of the month the eligibility was terminated.

Sec. 15. Minnesota Statutes 2014, section 256J.08, subdivision 26, is amended to read:

Subd. 26. **Earned income.** "Earned income" ~~means cash or in-kind income earned through the receipt of wages, salary, commissions, profit from employment activities, net profit from self-employment activities, payments made by an employer for regularly accrued vacation or sick leave, and any other profit from activity earned through effort or labor. The income must be in return for, or as a result of, legal activity~~ has the meaning given in section 256P.01, subdivision 3.

Sec. 16. Minnesota Statutes 2014, section 256J.08, subdivision 86, is amended to read:

Subd. 86. **Unearned income.** "Unearned income" ~~means income received by a person that does not meet the definition of earned income. Unearned income includes income from a contract for deed, interest, dividends, unemployment benefits, disability insurance payments, veterans benefits, pension payments, return on capital investment, insurance payments or settlements, severance payments, child support and maintenance payments, and payments for illness or disability whether the premium payments are made in whole or in part by an employer or participant~~ has the meaning given in section 256P.01, subdivision 8.

Sec. 17. Minnesota Statutes 2014, section 256J.30, subdivision 1, is amended to read:

Subdivision 1. **Applicant reporting requirements.** An applicant must provide information on an application form and supplemental forms about the applicant's circumstances ~~which affect MFIP eligibility or the assistance payment. An applicant must report changes identified in subdivision 9 while the application is pending. When an applicant does not accurately report information on an application, both an overpayment and a referral for a fraud investigation may result. When an applicant does not provide information or documentation, the receipt of the assistance payment may be delayed or the application may be denied depending on the type of information required and its effect on eligibility~~ according to section 256P.07.

Sec. 18. Minnesota Statutes 2014, section 256J.30, subdivision 9, is amended to read:

Subd. 9. **Changes that must be reported.** A caregiver must report ~~the changes or anticipated changes specified in clauses (1) to (15) within ten days of the date they occur, at the time of the periodic recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period as in subdivision 5, whichever occurs first. A caregiver must report other changes at the time of the periodic recertification of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period under subdivision 5, as applicable. A caregiver must make these reports in writing to the agency. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (14) had not occurred, the agency must determine whether a timely notice under section 256J.31, subdivision 4, could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 256J.38. Calculation of overpayments for late reporting under clause (15) is specified in section 256J.09, subdivision 9. Changes in circumstances which must be reported within ten days must also be reported on the MFIP household report form for the reporting period in which those changes occurred. Within ten days, a caregiver must report:~~ changes as specified under section 256P.07.

~~(1) a change in initial employment;~~

~~(2) a change in initial receipt of unearned income;~~

~~(3) a recurring change in unearned income;~~

~~(4) a nonrecurring change of unearned income that exceeds $30;~~

~~(5) the receipt of a lump sum;~~

~~(6) an increase in assets that may cause the assistance unit to exceed asset limits;~~

~~(7) a change in the physical or mental status of an incapacitated member of the assistance unit if the physical or mental status is the basis for reducing the hourly participation requirements under section 256J.55, subdivision 1, or the type of activities included in an employment plan under section 256J.521, subdivision 2;~~

~~(8) a change in employment status;~~

~~(9) the marriage or divorce of an assistance unit member;~~

~~(10) the death of a parent, minor child, or financially responsible person;~~

~~(11) a change in address or living quarters of the assistance unit;~~

~~(12) the sale, purchase, or other transfer of property;~~

~~(13) a change in school attendance of a caregiver under age 20 or an employed child;~~

~~(14) filing a lawsuit, a workers' compensation claim, or a monetary claim against a third party; and~~

~~(15) a change in household composition, including births, returns to and departures from the home of assistance unit members and financially responsible persons, or a change in the custody of a minor child.~~

Sec. 19. Minnesota Statutes 2014, section 256J.35, is amended to read:

256J.35 AMOUNT OF ASSISTANCE PAYMENT.

Except as provided in paragraphs (a) to (d), the amount of an assistance payment is equal to the difference between the MFIP standard of need or the Minnesota family wage level in section 256J.24 and countable income.

(a) Beginning July 1, 2015, MFIP assistance units are eligible for an MFIP housing assistance grant of $110 per month, unless:

(1) the housing assistance unit is currently receiving public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) and is subject to section 256J.37, subdivision 3a; or

(2) the assistance unit is a child-only case under section 256J.88.

(b) When MFIP eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision applies when an applicant loses at least one day of MFIP eligibility.

(c) MFIP overpayments to an assistance unit must be recouped according to section ~~256J.38, subdivision 4~~ 256P.08, subdivision 6.

(d) An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

Sec. 20. Minnesota Statutes 2014, section 256J.40, is amended to read:

256J.40 FAIR HEARINGS.

Caregivers receiving a notice of intent to sanction or a notice of adverse action that includes a sanction, reduction in benefits, suspension of benefits, denial of benefits, or termination of benefits may request a fair hearing. A request for a fair hearing must be submitted in writing to the county agency or to the commissioner and must be mailed within 30 days after a participant or former participant receives written notice of the agency's action or within 90 days when a participant or former participant shows good cause for not submitting the request within 30 days. A former participant who receives a notice of adverse action due to an overpayment may appeal the adverse action according to the requirements in this section. Issues that may be appealed are:

(1) the amount of the assistance payment;

(2) a suspension, reduction, denial, or termination of assistance;

(3) the basis for an overpayment, the calculated amount of an overpayment, and the level of recoupment;

(4) the eligibility for an assistance payment; and

(5) the use of protective or vendor payments under section 256J.39, subdivision 2, clauses (1) to (3).

Except for benefits issued under section 256J.95, a county agency must not reduce, suspend, or terminate payment when an aggrieved participant requests a fair hearing prior to the effective date of the adverse action or within ten days of the mailing of the notice of adverse action, whichever is later, unless the participant requests in writing not to receive continued assistance pending a hearing decision. An appeal request cannot extend benefits for the diversionary work program under section 256J.95 beyond the four-month time limit. Assistance issued pending a fair hearing is subject to recovery under section ~~256J.38~~ 256P.08 when as a result of the fair hearing decision the participant is determined ineligible for assistance or the amount of the assistance received. A county agency may increase or reduce an assistance payment while an appeal is pending when the circumstances of the participant change and are not related to the issue on appeal. The commissioner's order is binding on a county agency. No additional notice is required to enforce the commissioner's order.

A county agency shall reimburse appellants for reasonable and necessary expenses of attendance at the hearing, such as child care and transportation costs and for the transportation expenses of the appellant's witnesses and representatives to and from the hearing. Reasonable and necessary expenses do not include legal fees. Fair hearings must be conducted at a reasonable time and date by an impartial human services judge employed by the department. The hearing may be conducted by telephone or at a site that is readily accessible to persons with disabilities.

The appellant may introduce new or additional evidence relevant to the issues on appeal. Recommendations of the human services judge and decisions of the commissioner must be based on evidence in the hearing record and are not limited to a review of the county agency action.

Sec. 21. Minnesota Statutes 2014, section 256J.95, subdivision 19, is amended to read:

Subd. 19. **DWP overpayments and underpayments.** DWP benefits are subject to overpayments and underpayments. Anytime an overpayment or an underpayment is determined for DWP, the correction shall be calculated using prospective budgeting. Corrections shall be determined based on the policy in section 256J.34, subdivision 1,

paragraphs (a), (b), and (c). ATM errors must be recovered as specified in section ~~256J.38, subdivision 5~~ 256P.08, subdivision 7. Cross program recoupment of overpayments cannot be assigned to or from DWP.

Sec. 22. Minnesota Statutes 2014, section 256P.001, is amended to read:

256P.001 APPLICABILITY.

General assistance and Minnesota supplemental aid under chapter 256D, child care assistance programs under chapter 119B, and programs governed by chapter 256I or 256J are subject to the requirements of this chapter, unless otherwise specified or exempted.

Sec. 23. Minnesota Statutes 2014, section 256P.01, is amended by adding a subdivision to read:

Subd. 2a. **Assistance unit.** "Assistance unit" is defined by program area under sections 119B.011, subdivision 13; 256D.02, subdivision 1a; 256D.35, subdivision 3a; 256I.03, subdivision 1b; and 256J.08, subdivision 7.

Sec. 24. Minnesota Statutes 2014, section 256P.01, subdivision 3, is amended to read:

Subd. 3. **Earned income.** "Earned income" means cash or in-kind income earned through the receipt of wages, salary, commissions, bonuses, tips, gratuities, profit from employment activities, net profit from self-employment activities, payments made by an employer for regularly accrued vacation or sick leave, ~~and any~~ severance pay based on accrued leave time, payments from training programs at a rate at or greater than the state's minimum wage, royalties, honoraria, or other profit from activity ~~earned through effort~~ that results from the client's work, service, effort, or labor. The income must be in return for, or as a result of, legal activity.

Sec. 25. Minnesota Statutes 2014, section 256P.01, is amended by adding a subdivision to read:

Subd. 8. **Unearned income.** "Unearned income" has the meaning given in section 256P.06, subdivision 3, clause (2).

Sec. 26. Minnesota Statutes 2014, section 256P.02, is amended by adding a subdivision to read:

Subd. 1a. **Exemption.** Participants who qualify for child care assistance programs under chapter 119B are exempt from this section.

Sec. 27. Minnesota Statutes 2014, section 256P.03, subdivision 1, is amended to read:

Subdivision 1. **Exempted programs.** Participants who qualify for child care assistance programs under chapter 119B, Minnesota supplemental aid under chapter 256D, and ~~for~~ group residential housing under chapter 256I on the basis of eligibility for Supplemental Security Income are exempt from this section.

Sec. 28. Minnesota Statutes 2014, section 256P.04, subdivision 1, is amended to read:

Subdivision 1. **Exemption.** Participants who receive Minnesota supplemental aid and who maintain Supplemental Security Income eligibility under chapters 256D and 256I are exempt from the reporting requirements of this section, except that the policies and procedures for transfers of assets are those used by the medical assistance program under section 256B.0595. Participants who receive child care assistance under chapter 119B are exempt from the requirements of this section.

Sec. 29. Minnesota Statutes 2014, section 256P.04, subdivision 4, is amended to read:

Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

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

(6) vehicles;

(7) checking and savings accounts;

(8) inconsistent information, if related to eligibility;

(9) residence; ~~and~~

(10) Social Security number~~.~~; and

(11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item (ix), for the intended purpose in which it was given and received.

(b) Applicants who are qualified noncitizens and victims of domestic violence as defined under section 256J.08, subdivision 73, clause (7), are not required to verify the information in paragraph (a), clause (10). When a Social Security number is not provided to the agency for verification, this requirement is satisfied when each member of the assistance unit cooperates with the procedures for verification of Social Security numbers,

issuance of duplicate cards, and issuance of new numbers which have been established jointly between the Social Security Administration and the commissioner.

Sec. 30. Minnesota Statutes 2014, section 256P.05, subdivision 1, is amended to read:

Subdivision 1. **Exempted programs.** Participants who qualify for child care assistance programs under chapter 119B, Minnesota supplemental aid under chapter 256D, and ~~for~~ group residential housing under chapter 256I on the basis of eligibility for Supplemental Security Income are exempt from this section.

Sec. 31. **[256P.06] INCOME CALCULATIONS.**

Subdivision 1. **Reporting of income.** To determine eligibility, the county agency must evaluate income received by members of the assistance unit, or by other persons whose income is considered available to the assistance unit, and only count income that is available to the assistance unit. Income is available if the individual has legal access to the income.

Subd. 2. **Exempted individuals.** The following members of an assistance unit under chapters 119B and 256J are exempt from having their earned income count towards the income of an assistance unit:

(1) children under six years old;

(2) caregivers under 20 years of age enrolled at least half time in school; and

(3) minors enrolled in school full time.

Subd. 3. **Income inclusions.** The following must be included in determining the income of an assistance unit:

(1) earned income; and

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

(ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

(iii) proceeds from rent and contract for deed payments in excess of the principal and interest portion owed on property;

(iv) income from trusts, excluding special needs and supplemental needs trusts;

(v) interest income from loans made by the participant or household;

(vi) cash prizes and winnings;

(vii) unemployment insurance income;

(viii) retirement, survivors, and disability insurance payments;

(ix) nonrecurring income over $60 per quarter unless earmarked and used for the purpose for which it is intended. Income and use of this income is subject to verification requirements under section 256P.04;

(x) retirement benefits;

(xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I, and 256J;

(xii) tribal per capita payments unless excluded by federal and state law;

(xiii) income and payments from service and rehabilitation programs that meet or exceed the state's minimum wage rate;

(xiv) income from members of the United States armed forces unless excluded from income taxes according to federal or state law; and

(xv) child and spousal support.

Sec. 32. **[256P.07] REPORTING OF INCOME AND CHANGES.**

Subdivision 1. **Exempted programs.** Participants who qualify for Minnesota supplemental aid under chapter 256D and for group residential housing under chapter 256I on the basis of eligibility for Supplemental Security Income are exempt from this section.

Subd. 2. **Reporting requirements.** An applicant or participant must provide information on an application and any subsequent reporting forms about the assistance unit's circumstances that affect eligibility or benefits. An applicant or assistance unit must report changes identified in subdivision 3. When information is not accurately reported, both an overpayment and a referral for a fraud investigation may result. When information or documentation is not provided, the receipt of any benefit may be delayed or denied, depending on the type of information required and its effect on eligibility.

Subd. 3. **Changes that must be reported.** An assistance unit must report the changes or anticipated changes specified in clauses (1) to (12) within ten days of the date they occur, at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or within eight calendar days of a reporting period, whichever occurs first. An assistance unit must report other changes at the time of recertification of eligibility under section 256P.04, subdivisions 8 and 9, or at the end of a reporting period, as applicable. When an agency could have reduced or terminated assistance for one or more payment months if a delay in reporting a change specified under clauses (1) to (12) had not occurred, the agency must determine whether a timely notice could have been issued on the day that the change occurred. When a timely notice could have been issued, each month's overpayment subsequent to that notice must be considered a client error overpayment under section 119B.11, subdivision 2a; 256D.09, subdivision 6; 256D.49,

subdivision 3; 256J.38; or 256P.08. Changes in circumstances that must be reported within ten days must also be reported for the reporting period in which those changes occurred. Within ten days, an assistance unit must report a:

(1) change in earned income of $100 per month or greater;

(2) change in unearned income of $50 per month or greater;

(3) change in employment status and hours;

(4) change in address or residence;

(5) change in household composition with the exception of programs under chapter 256I;

(6) receipt of a lump-sum payment;

(7) increase in assets if over $9,000 with the exception of programs under chapter 119B;

(8) change in citizenship or immigration status;

(9) change in family status with the exception of programs under chapter 256I;

(10) change in disability status of a unit member, with the exception of programs under chapter 119B;

(11) new rent subsidy or a change in rent subsidy; and

(12) sale, purchase, or transfer of real property.

Subd. 4. **MFIP-specific reporting.** In addition to subdivision 3, an assistance unit under chapter 256J, within ten days of the change, must report:

(1) a pregnancy not resulting in birth when there are no other minor children; and

(2) a change in school attendance of a parent under 20 years of age or of an employed child.

Subd. 5. **DWP-specific reporting.** In addition to subdivisions 3 and 4, an assistance unit participating in the diversionary work program under section 256J.95 must report on an application:

(1) shelter expenses; and

(2) utility expenses.

Subd. 6. **Child care assistance programs-specific reporting.** In addition to subdivision 3, an assistance unit under chapter 119B, within ten days of the change, must report a:

(1) change in a parentally responsible individual's visitation schedule or custody arrangement for any child receiving child care assistance program benefits; and

(2) change in authorized activity status.

Subd. 7. **Minnesota supplemental aid-specific reporting.** In addition to subdivision 3, an assistance unit participating in the Minnesota supplemental aid program

under section 256D.44, subdivision 5, paragraph (f), within ten days of the change, must report shelter expenses.

Sec. 33. **[256P.08] CORRECTION OF OVERPAYMENTS AND UNDERPAYMENTS.**

Subdivision 1. **Exempted programs.** Participants who qualify for child care assistance programs under chapter 119B or group residential housing under chapter 256I are exempt from this section.

Subd. 2. **Scope of overpayment.** (a) When a participant or former participant receives an overpayment due to client or ATM error, or due to assistance received while an appeal is pending and the participant or former participant is determined ineligible for assistance or for less assistance than was received, except as provided for interim assistance in section 256D.06, subdivision 5, the county agency must recoup or recover the overpayment using the following methods:

(1) reconstruct each affected budget month and corresponding payment month;

(2) use the policies and procedures that were in effect for the payment month; and

(3) do not allow employment disregards in the calculation of the overpayment when the unit has not reported within two calendar months following the end of the month in which the income was received.

(b) Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(c) A participant or former participant is not responsible for overpayments due to agency error, unless the amount of the overpayment is large enough that a reasonable person would know it is an error.

Subd. 3. **Notice of overpayment.** When a county agency discovers that a participant or former participant has received an overpayment for one or more months, the county agency must notify the participant or former participant of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the authority for citing the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the participant's or former participant's right to appeal. No limit applies to the period in which the county agency is required to recoup or recover an overpayment according to subdivisions 5 and 6.

Subd. 4. **Recovering general assistance and Minnesota supplemental aid overpayments.** (a) If an amount of assistance is paid to an assistance unit in excess of the

payment due, it shall be recoverable by the agency. The agency shall give written notice to the participant of its intention to recover the overpayment.

(b) If the individual is no longer receiving assistance, the agency may request voluntary repayment or pursue civil recovery.

(c) If the individual is receiving assistance, except as provided for interim assistance in section 256D.06, subdivision 5, when an overpayment occurs the agency shall recover the overpayment by withholding an amount equal to:

(1) three percent of the assistance unit's standard of need for all Minnesota supplemental aid assistance units, and nonfraud cases for general assistance; and

(2) ten percent where fraud has occurred in general assistance cases; or

(3) the amount of the monthly general assistance or Minnesota supplemental aid payment, whichever is less.

(d) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(e) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the assistance reductions provided in this subdivision, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(f) The county agency shall make reasonable efforts to recover overpayments to individuals no longer on assistance. The agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

(g) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(h) Residents of licensed residential facilities shall not have overpayments recovered from their personal needs allowance.

(i) Overpayments by another maintenance benefit program shall not be recovered from the general assistance or Minnesota supplemental aid grant.

Subd. 5. **Recovering MFIP overpayments.** A county agency must initiate efforts to recover overpayments paid to a former participant or caregiver. Caregivers, both parental and nonparental, and minor caregivers of an assistance unit at the time an overpayment occurs, whether receiving assistance or not, are jointly and individually liable for repayment of the overpayment. The county agency must request repayment from the former participants and caregivers. When an agreement for repayment is not completed within six

months of the date of discovery or when there is a default on an agreement for repayment after six months, the county agency must initiate recovery consistent with chapter 270A or section 541.05. When a person has been convicted of fraud under section 256.98, recovery must be sought regardless of the amount of overpayment. When an overpayment is less than $35, and is not the result of a fraud conviction under section 256.98, the county agency must not seek recovery under this subdivision. The county agency must retain information about all overpayments regardless of the amount. When an adult, adult caregiver, or minor caregiver reapplies for assistance, the overpayment must be recouped under subdivision 6.

Subd. 6. **Recouping overpayments from MFIP participants.** A participant may voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this subdivision, until the total amount of the overpayment is repaid. When an overpayment occurs due to fraud, the county agency must recover from the overpaid assistance unit, including child-only cases, ten percent of the applicable standard or the amount of the monthly assistance payment, whichever is less. When a nonfraud overpayment occurs, the county agency must recover from the overpaid assistance unit, including child-only cases, three percent of the MFIP standard of need or the amount of the monthly assistance payment, whichever is less.

Subd. 7. **Recovering automatic teller machine errors.** For recipients receiving benefits by electronic benefit transfer, if the overpayment is a result of an ATM dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

Subd. 8. **Scope of underpayments.** A county agency must issue a corrective payment for underpayments made to a participant or to a person who would be a participant if an agency or client error causing the underpayment had not occurred. Corrective payments are limited to 12 months prior to the month of discovery. The county agency must issue the corrective payment according to subdivision 10.

Subd. 9. **Identifying the underpayment.** An underpayment may be identified by a county agency, participant, former participant, or person who would be a participant except for agency or client error.

Subd. 10. **Issuing corrective payments.** A county agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment of the participant, issuing a separate payment to a participant or former participant, or reducing an existing overpayment balance. When an underpayment occurs in a payment month and is not identified until the next payment month or later, the county agency must first

subtract the underpayment from any overpayment balance before issuing the corrective payment. The county agency must not apply an underpayment in a current payment month against an overpayment balance. When an underpayment in the current payment month is identified, the corrective payment must be issued within seven calendar days after the underpayment is identified. Corrective payments must be excluded when determining the applicant's or participant's income and resources for the month of payment. The county agency must correct underpayments using the following methods:

(1) reconstruct each affected budget month and corresponding payment month; and

(2) use the policies and procedures that were in effect for the payment month.

Subd. 11. **Appeals.** A participant may appeal an underpayment, an overpayment, and a reduction in an assistance payment made to recoup the overpayment under subdivisions 4 and 6. The participant's appeal of each issue must be timely under section 256.045. When an appeal based on the notice issued under subdivision 3 is not timely, the fact or the amount of that overpayment must not be considered as a part of a later appeal, including an appeal of a reduction in an assistance payment to recoup that overpayment.

Sec. 34. **REPEALER.**

(a) Minnesota Statutes 2014, sections 256D.0513; 256D.06, subdivision 8; 256D.09, subdivision 6; 256D.49; and 256J.38, are repealed.

(b) Minnesota Rules, part 3400.0170, subparts 5, 6, 12, and 13, are repealed.

Sec. 35. **EFFECTIVE DATE.**

Sections 1 to 34 are effective August 1, 2016.

ARTICLE 13

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2013, chapter 108, article 14, as amended by Laws 2014, chapter 312, article 30, from the general fund, or any other fund named, to the Department of Human Services for the purposes specified in this article, to be available for the fiscal years indicated for each purpose. The figure "2015" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2015.

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ (255,104,000)**

	Appropriations by Fund
	2015
General Fund	(125,910,000)
Health Care Access	(123,113,000)
TANF	(6,081,000)

Subd. 2. **Forecasted Programs**

(a) **MFIP/DWP Grants**

	Appropriations by Fund
General Fund	(1,977,000)
TANF	(7,079,000)

(b) **MFIP Child Care Assistance Grants** 9,733,000

(c) **General Assistance Grants** (1,423,000)

(d) **Minnesota Supplemental Aid Grants** (1,121,000)

(e) **Group Residential Housing Grants** (6,314,000)

(f) **MinnesotaCare Grants** (75,675,000)

This appropriation is from the health care access fund.

(g) **Medical Assistance Grants**

	Appropriations by Fund
General Fund	(124,557,000)
Health Care Access	(47,438,000)

(h) **Alternative Care Grants** 0

(i) **CD Entitlement Grants** (251,000)

Subd. 3. **Technical Activities** 998,000

This appropriation is from the TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 14

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2016" and "2017" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2016, or June 30, 2017, respectively. "The first year" is fiscal year 2016. "The second year" is fiscal year 2017. "The biennium" is fiscal years 2016 and 2017.

	APPROPRIATIONS Available for the Year Ending June 30	
	2016	**2017**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**		**$**	**6,780,637,000**	**$**	**6,830,093,000**

Appropriations by Fund

	2016	2017
General	5,530,299,000	5,953,258,000
State Government Special Revenue	4,514,000	4,274,000
Health Care Access	969,037,000	599,313,000
Federal TANF	274,897,000	271,358,000
Lottery Prize	1,890,000	1,890,000

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of the Office of MN.IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended

balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

TANF Maintenance of Effort. (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671; and

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (7), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(e) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in

excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

(f) For the purposes of paragraph (e), clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(g) Notwithstanding any contrary provision in this article, paragraphs (a) to (f) expire June 30, 2019.

Working Family Credit Expenditure as TANF/MOE. The commissioner may claim as TANF maintenance of effort up to $6,707,000 per year of working family credit expenditures in each fiscal year.

Subd. 2. **Central Office**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Operations**

	Appropriations by Fund	
General	87,842,000	82,809,000
State Government Special Revenue	4,389,000	4,149,000
Health Care Access	12,826,000	12,841,000
Federal TANF	100,000	100,000

Administrative Recovery; Set-Aside. The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

IT Appropriations Generally. This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid

to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Children and Families**

	Appropriations by Fund	
General	8,476,000	8,267,000
Federal TANF	2,582,000	2,582,000

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2016 and fiscal year 2017 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Child Support Work Group. $12,000 in fiscal year 2016 is from the general fund for facilitation of the duties of the child support work group.

Stearns County Veterans Housing. $85,000 in fiscal year 2016 and $85,000 in fiscal year 2017 are from the general fund for a grant to Stearns County to provide administrative funding in support of a service provider serving veterans in Stearns County. The administrative funding grant may be used to support group residential housing services, corrections-related services, veteran services, and other social services related to the service

provider serving veterans in Stearns County.

This is a onetime appropriation.

(c) **Health Care**

	Appropriations by Fund	
General	15,932,000	20,036,000
Health Care Access	24,764,000	24,122,000

(d) **Continuing Care**

	Appropriations by Fund	
General	27,585,000	25,786,000
State Government Special Revenue	125,000	125,000

Nursing Facilities. $890,000 in fiscal year 2016 is from the general fund for the nursing facility property rate setting appraisals and study. This is a onetime appropriation.

(e) **Chemical and Mental Health**

	Appropriations by Fund	
General	4,895,000	5,095,000
Lottery Prize	157,000	157,000

Subd. 3. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP**

	Appropriations by Fund	
General	82,355,000	86,086,000
Federal TANF	93,093,000	88,798,000

(b) **MFIP Child Care Assistance**	98,920,000	105,921,000
(c) **General Assistance**	55,117,000	57,847,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203.

The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2016 and $6,729,812 in fiscal year 2017. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

(d) **Minnesota Supplemental Aid**	39,668,000	41,169,000
(e) **Group Residential Housing**	155,753,000	167,194,000
(f) **Northstar Care for Children**	41,096,000	46,336,000
(g) **MinnesotaCare**	234,982,000	20,854,000

This appropriation is from the health care access fund.

(h) **Medical Assistance**

Appropriations by Fund		
General	4,180,159,000	4,565,620,000
Health Care Access	692,374,000	537,281,000

Contingent Rate Reductions. If the commissioner determines that contract negotiations to reduce managed care and county-based purchasing plan administrative costs, and implementation of statewide competitive bidding, will not achieve a state general fund savings of $150,000,000 for the biennium beginning July 1, 2015, the commissioner shall calculate an estimate of the shortfall in savings, and, for the fiscal year beginning July 1, 2016, shall reduce medical assistance provider payment rates, including but not limited to rates to

individual health care providers and provider agencies, hospitals, other residential settings, and capitation rates provided to managed care and county-based purchasing plans, but excluding nursing facilities, by the amount necessary to recoup the shortfall in savings over that fiscal year.

Base Adjustment. The health care access fund base for medical assistance is $476,236,000 in fiscal year 2018 and $275,118,000 in fiscal year 2019.

(i) **Alternative Care**	42,704,000	43,421,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

(j) **Chemical Dependency Treatment Fund**	81,863,000	85,660,000

Subd. 4. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

	Appropriations by Fund	
General	13,133,000	8,715,000
Federal TANF	96,311,000	96,311,000

(b) **Basic Sliding Fee Child Care Assistance Grants**	44,318,000	47,518,000
(c) **Child Care Development Grants**	1,737,000	1,737,000
(d) **Child Support Enforcement Grants**	50,000	50,000

(e) **Children's Services Grants**

	Appropriations by Fund	
General	39,015,000	38,665,000
Federal TANF	140,000	140,000

Safe Place for Newborns. $350,000 in fiscal year 2016 is from the general fund to distribute information on the Safe Place for Newborns law in Minnesota. The purpose of this appropriation is to increase public awareness of the law.

Title IV-E Adoption Assistance. Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2016 and 2017 for adoption incentive grants are appropriated to the commissioner for these purposes.

(f) **Children and Community Service Grants**	56,301,000	56,301,000
(g) **Children and Economic Support Grants**	25,281,000	25,291,000

Homeless Youth Act. $2,000,000 in fiscal year 2016 and $2,000,000 in fiscal year 2017 are from the general fund for purposes of Minnesota Statutes, section 256K.45.

Mobile Food Shelf Grants. (a) $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for transfer to Hunger Solutions. This is a onetime appropriation and is available until June 30, 2017.

(b) Hunger Solutions shall award grants of up to $75,000 on a competitive basis. Grant applications must include:

(1) the location of the project;

(2) a description of the mobile program, including size and scope;

(3) evidence regarding the unserved or underserved nature of the community in which the project is to be located;

(4) evidence of community support for the project;

(5) the total cost of the project;

(6) the amount of the grant request and how funds will be used;

(7) sources of funding or in-kind contributions for the project that will supplement any grant award;

(8) a commitment to mobile programs by the applicant and an ongoing commitment to maintain the mobile program; and

(9) any additional information requested by Hunger Solutions.

(c) Priority may be given to applicants who:

(1) serve underserved areas;

(2) create a new or expand an existing mobile program;

(3) serve areas where a high amount of need is identified;

(4) provide evidence of strong support for the project from citizens and other institutions in the community;

(5) leverage funding for the project from other private and public sources; and

(6) commit to maintaining the program on a multilayer basis.

Safe Harbor. (a) $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for emergency shelter and transitional and long-term housing beds for sexually exploited youth and youth at risk of sexual exploitation.

(b) $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are from the general fund for statewide youth outreach workers connecting sexually exploited youth and youth at risk of sexual exploitation with shelter and services.

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2016 do not cancel but are available for this purpose in fiscal year 2017.

(h) **Health Care Grants**

	Appropriations by Fund	
General	410,000	410,000
Health Care Access	3,341,000	3,465,000

(i) **Other Long-Term Grants** 1,551,000 3,069,000

(j) **Aging and Adult Services Grants** 28,463,000 29,407,000

Dementia Grants. $750,000 in fiscal year 2016 and $750,000 in fiscal year 2017 are from the general fund for the Minnesota Board on Aging for regional and local dementia grants authorized in Minnesota Statutes, section 256.975, subdivision 11. This amount shall be added to the base. Up to one percent of each appropriation may be used by the board to administer the regional and local dementia grants.

(k) **Deaf and Hard-of-Hearing Grants** 2,875,000 2,961,000

Deaf and Hard-of-Hearing Services Division. $650,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the general fund for the Deaf and Hard-of-Hearing Services Division under Minnesota Statutes, 256C.233. This appropriation is added to the base. The funds must be used:

(1) to provide linguistically and culturally appropriate mental health services;

(2) to ensure that each regional advisory committee meets at least quarterly;

(3) to increase the number of deafblind Minnesotans receiving services;

(4) to conduct an analysis of how the regional offices and staff are operated, in consultation with the Commission of Deaf, DeafBlind, and Hard of Hearing Minnesotans;

(5) during fiscal year 2016, to provide direct services to clients and purchase additional technology for the technology labs; and

(6) to conduct an analysis of whether deafblind services are being provided in the best and most efficient way possible, with input from deafblind Minnesotans receiving services.

Grants. $350,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the general fund for deaf and hard-of-hearing grants. The funds must be used to increase the number of deafblind Minnesotans receiving services under Minnesota Statutes, section 256C.261, and to provide linguistically and culturally appropriate mental health services

to children who are deaf, deafblind, and hard-of-hearing.

(l) **Disabilities Grants** 20,647,000 22,045,000

(m) **Adult Mental Health Grants**

Appropriations by Fund		
General	71,042,000	71,542,000
Health Care Access	750,000	750,000
Lottery Prize	1,733,000	1,733,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Comprehensive Mental Health Center. $1,500,000 for the 2016-2017 biennium is from the general fund for a grant to Beltrami County to fund the planning and development of a comprehensive mental health center.

Problem Gambling. $225,000 in fiscal year 2016 and $225,000 in fiscal year 2017 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(n) **Child Mental Health Grants** 23,136,000 23,963,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that

portion of the fiscal year ending December 31.

Special Projects. (a) $600,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the general fund to fund special projects to provide intensive treatment and supports to adolescents and young adults who are experiencing their first psychotic or manic episode. Projects must utilize all available funding streams.

(b) Of the fiscal year 2016 appropriation, $100,000 must be used by the special projects to conduct outreach, training, and guidance. This money is available until spent.

Chemical Dependency Prevention. $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are from the general fund for grants to nonprofit organizations to provide chemical dependency prevention programs in secondary schools. When making grants, the commissioner must consider the expertise, prior experience, and outcomes achieved by applicants that have provided prevention programming in secondary education environments. An applicant for the grant funds must provide verification to the commissioner that the applicant has available and will contribute sufficient funds to match the grant given by the commissioner. Unspent funds cancel at the end of each fiscal year.

(o) **Chemical Dependency Treatment Support Grants**	1,161,000	1,161,000

Subd. 5. **DCT State-Operated Services**

Transfer Authority for State-Operated Services. Money appropriated for

state-operated services may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) **DCT State-Operated Services Mental Health**	124,319,000	124,290,000

Dedicated Receipts Available. Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a), up to $1,000,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (1); up to $1,000,000 each year is available to transfer to the adult mental health grants budget activity for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (2); and up to $2,713,000 each year is available for the purposes of Minnesota Statutes, section 246.18, subdivision 8, paragraph (b), clause (3).

(b) **DCT State-Operated Services Enterprise Services**	-0-	385,000
(c) **DCT State-Operated Services Minnesota Security Hospital**	74,750,000	74,756,000
Subd. 6. **DCT Minnesota Sex Offender Program**	79,745,000	79,745,000

Transfer Authority for Minnesota Sex Offender Program. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 7. **Technical Activities** 82,671,000 83,427,000

This appropriation is from the federal TANF fund.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **156,186,000** **$** **154,326,000**

Appropriations by Fund

	2016	2017
General	89,351,000	88,078,000
State Government Special Revenue	51,706,000	51,719,000
Health Care Access	11,243,000	10,643,000
Federal TANF	3,886,000	3,886,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	70,012,000	68,747,000
State Government Special Revenue	6,177,000	6,072,000
Health Care Access	11,243,000	10,643,000
Federal TANF	3,886,000	3,886,000

(a) $250,000 in the biennium ending June 30, 2017, is from the general fund to award a grant to a statewide advance care planning resource organization that has expertise in convening and coordinating community-based strategies to encourage individuals, families, caregivers, and health care providers to begin conversations regarding end-of-life care choices that express an individual's health care values and preferences and are based on informed health care decisions. This is a onetime appropriation.

(b) $200,000 in fiscal year 2016 is from the general fund to provide a grant to the Leech Lake Band of Ojibwe ambulance service for equipment upgrades.

(c) $800,000 in fiscal year 2016 and $800,000 in fiscal year 2017 are from the general fund for regional poison information centers under Minnesota Statutes, section 145.93. This appropriation is added to the base.

(d) $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund to provide subsidies to federally qualified health centers under Minnesota Statutes, section 145.9269. This is a onetime appropriation.

(e) $350,000 in fiscal year 2016 and $350,000 in fiscal year 2017 are from the general fund for the Minnesota stroke system under the heart disease and stroke prevention unit under the Department of Health.

(f) $500,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are from the general fund for the Smile Healthy Minnesota 2016 grant program under Minnesota Statutes, section 145.9299. The appropriation is available until expended.

(g) $200,000 in fiscal year 2016 is from the general fund for the purposes of establishing a grant program used to develop and create culturally appropriate outreach programs that provide education about the importance of organ donation. Grants shall be awarded to a federally designated organ procurement organization and hospital system that

performs transplants. This is a onetime appropriation.

(h) $6,500,000 in fiscal year 2016 and $6,500,000 in fiscal year 2017 are from the general fund for the purposes of the primary care residency expansion grant program under Minnesota Statutes, section 144.1506.

(i) $250,000 in fiscal year 2016 is from the general fund for a grant to a community health center to partner with a nonprofit organization that helps Somali women, for the community health center and nonprofit organization to do the following:

(1) choose a primary care physician;

(2) provide high quality, compassionate, and ethically sound health care services to all;

(3) engage in dialogue with patients to determine their care expectations;

(4) counsel patients regarding the benefits of preventative health care and early screening, intervention, and treatment; and

(5) advocate for increased public awareness of the benefits of preventative health care and early screening and intervention.

The community health center shall report the progress of the nonprofit organization to the commissioner by July 1, 2016. This is a onetime appropriation.

(j) $270,000 in fiscal year 2016 and $20,000 in fiscal year 2017 are from the general fund to the commissioner of health for grants to educate emergency medical services persons on the use of an opiate antagonist in the event of an opioid of heroin overdose. The funding

must be distributed proportionately to the eight regional emergency medical services programs based on the need of the regions, as determined by the commissioner by using existing data. The regional emergency medical services programs must submit an application for a grant to the commissioner by September 1, 2015. This is a onetime appropriation.

(k) $1,500,000 in fiscal year 2016 and $1,500,000 in fiscal year 2017 are from the general fund for the purposes of the home and community-based services employee scholarship program under Minnesota Statutes, section 144.1503.

TANF Appropriations. (a) $1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(b) $2,000,000 of the TANF funds is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(c) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	12,381,000	12,381,000
State Government Special Revenue	45,529,000	45,647,000

Subd. 4. **Administrative Support Services**	6,958,000	6,950,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 19,707,000**	**$ 19,597,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	507,000	513,000
Subd. 3. **Board of Dentistry**	2,192,000	2,206,000

This appropriation includes $864,000 in fiscal year 2016 and $878,000 in fiscal year 2017 for the health professional services program.

Subd. 4. **Board of Dietetics and Nutrition Practice**	113,000	115,000
Subd. 5. **Board of Marriage and Family Therapy**	234,000	237,000
Subd. 6. **Board of Medical Practice**	3,933,000	3,962,000
Subd. 7. **Board of Nursing**	4,189,000	4,243,000
Subd. 8. **Board of Nursing Home Administrators**	2,365,000	2,062,000

Administrative Services Unit - Operating Costs. Of this appropriation, $1,482,000 in fiscal year 2016 and $1,497,000 in fiscal year 2017 are for operating costs

of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Retirement Costs. Of this appropriation, $320,000 in fiscal year 2016 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring the retirement costs. These funds are available either year of the biennium.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2016 and $200,000 in fiscal year 2017 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for

payment of those costs with the approval of the commissioner of management and budget.

Subd. 9. **Board of Optometry**	138,000	143,000
Subd. 10. **Board of Pharmacy**	2,847,000	2,888,000
Subd. 11. **Board of Physical Therapy**	354,000	359,000
Subd. 12. **Board of Podiatry**	78,000	79,000
Subd. 13. **Board of Psychology**	874,000	884,000
Subd. 14. **Board of Social Work**	1,141,000	1,155,000
Subd. 15. **Board of Veterinary Medicine**	262,000	265,000
Subd. 16. **Board of Behavioral Health and Therapy**	480,000	486,000

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 2,773,000 $ 2,772,000**

Regional Grants. $585,000 in fiscal year 2016 and $585,000 in fiscal year 2017 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions.

Cooper/Sams Volunteer Ambulance Program. (a) $700,000 in fiscal year 2016 and $700,000 in fiscal year 2017 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(b) Of this amount, $611,000 in fiscal year 2016 and $611,000 in fiscal year 2017 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(c) Of this amount, $89,000 in fiscal year 2016 and $89,000 in fiscal year 2017 are for the operations of the ambulance service personnel longevity award and incentive

program under Minnesota Statutes, section 144E.40.

Ambulance Training Grants. $361,000 in fiscal year 2016 and $361,000 in fiscal year 2017 are for training grants.

EMSRB Board Operations. $1,095,000 in fiscal year 2016 and $1,095,000 in fiscal year 2017 are for board operations.

Sec. 6. **COUNCIL ON DISABILITY** **$ 795,000 $ 761,000**

(a) $69,000 each fiscal year is for one full-time equivalent to coordinate the Minnesota State Council on Disability's communication with the disability community.

(b) $78,000 in fiscal years 2016 and 2017 is from the general fund to provide consultation services to state agencies, developers, and the public regarding compliance with the State Building Code and the Americans with Disabilities Act.

(c) $30,000 in fiscal year 2016 is for a computer system upgrade and installation to track agency performance and services provided to the public.

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 1,829,000 $ 1,854,000**

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 334,000 $ 334,000**

Sec. 9. **COMMISSIONER OF COMMERCE** **$ 210,000 $ 213,000**

The commissioner of commerce shall use existing grants issued by the federal government for the exchange to establish

a federally facilitated exchange as required under article 3, section 24.

Sec. 10. **APPROPRIATION.**

$196,000,000 is appropriated in fiscal year 2015 from the general fund to the commissioner of human services for transfer to the health care access fund. These funds do not cancel until June 30, 2017. Notwithstanding any law to the contrary, these funds are not subject to transfer.

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

Sec. 11. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision to read:

Subd. 40. **Nonfederal share transfers.** The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

Sec. 12. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2017, within fiscal years among the MFIP, general assistance, general assistance medical care under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of

representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2017, unless a different expiration date is explicit.

Sec. 15. **EFFECTIVE DATE.**

This article is effective July 1, 2015, unless a different effective date is specified.

APPENDIX
Article locations in H1638-2

13.461 HUMAN SERVICES DATA CODED ELSEWHERE.

Subd. 26. **MinnesotaCare.** Data sharing with other government agencies that is needed to verify income for eligibility and premium payment is governed by section 256L.05.

13D.08 OPEN MEETING LAW CODED ELSEWHERE.

Subd. 5a. **MNsure.** Meetings of MNsure are governed by section 62V.03, subdivision 2.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 3. **MinnesotaCare federal receipts.** All federal funding received by Minnesota for implementation and administration of MinnesotaCare as a basic health program, as authorized in section 1331 of the Affordable Care Act, Public Law 111-148, as amended by Public Law 111-152, is appropriated to the commissioner of human services to be used only for the MinnesotaCare program under chapter 256L. Federal funding that is received for implementing and administering MinnesotaCare as a basic health program shall be used only for that program to purchase health care coverage for enrollees and reduce enrollee premiums and cost-sharing or provide additional enrollee benefits.

62A.046 COORDINATION OF BENEFITS.

Subd. 5. **Payment recovery.** The commissioner of human services shall recover payments made by the MinnesotaCare program from the responsible insurer, for services provided by the MinnesotaCare program and covered by the policy or plan of health insurance.

62V.01 TITLE.

This chapter may be cited as the "MNsure Act."

62V.02 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Board.** "Board" means the Board of Directors of MNsure specified in section 62V.04.

Subd. 3. **Dental plan.** "Dental plan" has the meaning defined in section 62Q.76, subdivision 3.

Subd. 4. **Health plan.** "Health plan" means a policy, contract, certificate, or agreement defined in section 62A.011, subdivision 3.

Subd. 5. **Health carrier.** "Health carrier" has the meaning defined in section 62A.011.

Subd. 6. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals.

Subd. 7. **Insurance producer.** "Insurance producer" has the meaning defined in section 60K.31.

Subd. 8. **MNsure.** "MNsure" means the state health benefit exchange as described in section 1311 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

Subd. 9. **Navigator.** "Navigator" has the meaning described in section 1311(i) of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

Subd. 10. **Public health care program.** "Public health care program" means any public health care program administered by the commissioner of human services.

Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148, and has been certified by the board in accordance with section 62V.05, subdivision 5, to be offered through MNsure.

Subd. 12. **Small group market.** "Small group market" means the market for health insurance coverage offered to small employers as defined in section 62L.02, subdivision 26.

Subd. 13. **Web site.** "Web site" means a site maintained on the World Wide Web by MNsure that allows for access to information and services provided by MNsure.

62V.03 MNSURE; ESTABLISHMENT.

Subdivision 1. **Creation.** MNsure is created as a board under section 15.012, paragraph (a), to:

(1) promote informed consumer choice, innovation, competition, quality, value, market participation, affordability, suitable and meaningful choices, health improvement, care management, reduction of health disparities, and portability of health plans;

(2) facilitate and simplify the comparison, choice, enrollment, and purchase of health plans for individuals purchasing in the individual market through MNsure and for employees and employers purchasing in the small group market through MNsure;

(3) assist small employers with access to small business health insurance tax credits and to assist individuals with access to public health care programs, premium assistance tax credits and cost-sharing reductions, and certificates of exemption from individual responsibility requirements;

(4) facilitate the integration and transition of individuals between public health care programs and health plans in the individual or group market and develop processes that, to the maximum extent possible, provide for continuous coverage; and

(5) establish and modify as necessary a name and brand for MNsure based on market studies that show maximum effectiveness in attracting the uninsured and motivating them to take action.

Subd. 2. **Application of other law.** (a) MNsure must be reviewed by the legislative auditor under section 3.971. The legislative auditor shall audit the books, accounts, and affairs of MNsure once each year or less frequently as the legislative auditor's funds and personnel permit. Upon the audit of the financial accounts and affairs of MNsure, MNsure is liable to the state for the total cost and expenses of the audit, including the salaries paid to the examiners while actually engaged in making the examination. The legislative auditor may bill MNsure either monthly or at the completion of the audit. All collections received for the audits must be deposited in the general fund and are appropriated to the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit Commission is requested to direct the legislative auditor to report by March 1, 2014, to the legislature on any duplication of services that occurs within state government as a result of the creation of MNsure. The legislative auditor may make recommendations on consolidating or eliminating any services deemed duplicative. The board shall reimburse the legislative auditor for any costs incurred in the creation of this report.

(b) Board members of MNsure are subject to sections 10A.07 and 10A.09. Board members and the personnel of MNsure are subject to section 10A.071.

(c) All meetings of the board shall comply with the open meeting law in chapter 13D, except that:

(1) meetings, or portions of meetings, regarding compensation negotiations with the director or managerial staff may be closed in the same manner and according to the same procedures identified in section 13D.03;

(2) meetings regarding contract negotiation strategy may be closed in the same manner and according to the same procedures identified in section 13D.05, subdivision 3, paragraph (c); and

(3) meetings, or portions of meetings, regarding not public data described in section 62V.06, subdivision 3, and regarding trade secret information as defined in section 13.37, subdivision 1, paragraph (b), are closed to the public, but must otherwise comply with the procedures identified in chapter 13D.

(d) MNsure and provisions specified under this chapter are exempt from:

(1) chapter 14, including section 14.386, except as specified in section 62V.05; and

(2) chapters 16B and 16C, with the exception of sections 16C.08, subdivision 2, paragraph (b), clauses (1) to (8); 16C.086; 16C.09, paragraph (a), clauses (1) and (3), paragraph (b), and paragraph (c); and section 16C.16. However, MNsure, in consultation with the commissioner of administration, shall implement policies and procedures to establish an open and competitive procurement process for MNsure that, to the extent practicable, conforms to the principles and procedures contained in chapters 16B and 16C. In addition, MNsure may enter into an agreement with the commissioner of administration for other services.

(e) The board and the Web site are exempt from chapter 60K. Any employee of MNsure who sells, solicits, or negotiates insurance to individuals or small employers must be licensed as an insurance producer under chapter 60K.

(f) Section 3.3005 applies to any federal funds received by MNsure.

(g) MNsure is exempt from the following sections in chapter 16E: 16E.01, subdivision 3, paragraph (b); 16E.03, subdivisions 3 and 4; 16E.04, subdivision 1, subdivision 2, paragraph (c), and subdivision 3, paragraph (b); 16E.0465; 16E.055; 16E.145; 16E.15; 16E.16; 16E.17; 16E.18; and 16E.22.

(h) A MNsure decision that requires a vote of the board, other than a decision that applies only to hiring of employees or other internal management of MNsure, is an "administrative action" under section 10A.01, subdivision 2.

Subd. 3. **Continued operation of a private marketplace.** (a) Nothing in this chapter shall be construed to prohibit: (1) a health carrier from offering outside of MNsure a health plan to a qualified individual or qualified employer; and (2) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of MNsure.

(b) Nothing in this chapter shall be construed to restrict the choice of a qualified individual to enroll or not enroll in a qualified health plan or to participate in MNsure. Nothing in this chapter shall be construed to compel an individual to enroll in a qualified health plan or to participate in MNsure.

(c) For purposes of this subdivision, "qualified individual" and "qualified employer" have the meanings given in section 1312 of the Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

62V.04 GOVERNANCE.

Subdivision 1. **Board.** MNsure is governed by a board of directors with seven members.

Subd. 2. **Appointment.** (a) Board membership of MNsure consists of the following:

(1) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d), with one member representing the interests of individual consumers eligible for individual market coverage, one member representing individual consumers eligible for public health care program coverage, and one member representing small employers. Members are appointed to serve four-year terms following the initial staggered-term lot determination;

(2) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d) who have demonstrated expertise, leadership, and innovation in the following areas: one member representing the areas of health administration, health care finance, health plan purchasing, and health care delivery systems; one member representing the areas of public health, health disparities, public health care programs, and the uninsured; and one member representing health policy issues related to the small group and individual markets. Members are appointed to serve four-year terms following the initial staggered-term lot determination; and

(3) the commissioner of human services or a designee.

(b) Section 15.0597 shall apply to all appointments, except for the commissioner.

(c) The governor shall make appointments to the board that are consistent with federal law and regulations regarding its composition and structure. All board members appointed by the governor must be legal residents of Minnesota.

(d) Upon appointment by the governor, a board member shall exercise duties of office immediately. If both the house of representatives and the senate vote not to confirm an appointment, the appointment terminates on the day following the vote not to confirm in the second body to vote.

(e) Initial appointments shall be made by April 30, 2013.

(f) One of the six members appointed under paragraph (a), clause (1) or (2), must have experience in representing the needs of vulnerable populations and persons with disabilities.

(g) Membership on the board must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 3. **Terms.** (a) Board members may serve no more than two consecutive terms, except for the commissioner or the commissioner's designee, who shall serve until replaced by the governor.

(b) A board member may resign at any time by giving written notice to the board.

(c) The appointed members under subdivision 2, paragraph (a), clauses (1) and (2), shall have an initial term of two, three, or four years, determined by lot by the secretary of state.

Subd. 4. **Conflicts of interest.** (a) Within one year prior to or at any time during their appointed term, board members appointed under subdivision 2, paragraph (a), clauses (1) and (2), shall not be employed by, be a member of the board of directors of, or otherwise be a representative of a health carrier, institutional health care provider or other entity providing health care, navigator, insurance producer, or other entity in the business of selling items or services of

significant value to or through MNsure. For purposes of this paragraph, "health care provider or entity" does not include an academic institution.

(b) Board members must recuse themselves from discussion of and voting on an official matter if the board member has a conflict of interest. A conflict of interest means an association including a financial or personal association that has the potential to bias or have the appearance of biasing a board member's decisions in matters related to MNsure or the conduct of activities under this chapter.

(c) No board member shall have a spouse who is an executive of a health carrier.

(d) No member of the board may currently serve as a lobbyist, as defined under section 10A.01, subdivision 21.

Subd. 5. **Acting chair; first meeting; supervision.** (a) The governor shall designate as acting chair one of the appointees described in subdivision 2.

(b) The board shall hold its first meeting within 60 days of enactment.

(c) The board shall elect a chair to replace the acting chair at the first meeting.

Subd. 6. **Chair.** The board shall have a chair, elected by a majority of members. The chair shall serve for one year.

Subd. 7. **Officers.** The members of the board shall elect officers by a majority of members. The officers shall serve for one year.

Subd. 8. **Vacancies.** If a vacancy occurs, the governor shall appoint a new member within 90 days, and the newly appointed member shall be subject to the same confirmation process described in subdivision 2.

Subd. 9. **Removal.** (a) A board member may be removed by the appointing authority and a majority vote of the board following notice and hearing before the board. For purposes of this subdivision, the appointing authority or a designee of the appointing authority shall be a voting member of the board for purposes of constituting a quorum.

(b) A conflict of interest as defined in subdivision 4, shall be cause for removal from the board.

Subd. 10. **Meetings.** The board shall meet at least quarterly.

Subd. 11. **Quorum.** A majority of the members of the board constitutes a quorum, and the affirmative vote of a majority of members of the board is necessary and sufficient for action taken by the board.

Subd. 12. **Compensation.** (a) The board members shall be paid a salary not to exceed the salary limits established under section 15A.0815, subdivision 4. The salary for board members shall be set in accordance with this subdivision and section 15A.0815, subdivision 5. This paragraph expires December 31, 2015.

(b) Beginning January 1, 2016, the board members may be compensated in accordance with section 15.0575.

Subd. 13. **Advisory committees.** (a) The board shall establish and maintain advisory committees to provide insurance producers, health care providers, the health care industry, consumers, and other stakeholders with the opportunity to advise the board regarding the operation of MNsure as required under section 1311(d)(6) of the Affordable Care Act, Public Law 111-148. The board shall regularly consult with the advisory committees. The advisory committees established under this paragraph shall not expire.

(b) The board may establish additional advisory committees, as necessary, to gather and provide information to the board in order to facilitate the operation of MNsure. The advisory committees established under this paragraph shall not expire, except by action of the board.

(c) Section 15.0597 shall not apply to any advisory committee established by the board under this subdivision.

(d) The board may provide compensation and expense reimbursement under section 15.059, subdivision 3, to members of the advisory committees.

62V.05 RESPONSIBILITIES AND POWERS OF MNSURE.

Subdivision 1. **General.** (a) The board shall operate MNsure according to this chapter and applicable state and federal law.

(b) The board has the power to:

(1) employ personnel and delegate administrative, operational, and other responsibilities to the director and other personnel as deemed appropriate by the board. This authority is subject to chapters 43A and 179A. The director and managerial staff of MNsure shall serve in the unclassified service and shall be governed by a compensation plan prepared by the board, submitted to the commissioner of management and budget for review and comment within 14

days of its receipt, and approved by the Legislative Coordinating Commission and the legislature under section 3.855, except that section 15A.0815, subdivision 5, paragraph (e), shall not apply;

(2) establish the budget of MNsure;

(3) seek and accept money, grants, loans, donations, materials, services, or advertising revenue from government agencies, philanthropic organizations, and public and private sources to fund the operation of MNsure. No health carrier or insurance producer shall advertise on MNsure;

(4) contract for the receipt and provision of goods and services;

(5) enter into information-sharing agreements with federal and state agencies and other entities, provided the agreements include adequate protections with respect to the confidentiality and integrity of the information to be shared, and comply with all applicable state and federal laws, regulations, and rules, including the requirements of section 62V.06; and

(6) exercise all powers reasonably necessary to implement and administer the requirements of this chapter and the Affordable Care Act, Public Law 111-148.

(c) The board shall establish policies and procedures to gather public comment and provide public notice in the State Register.

(d) Within 180 days of enactment, the board shall establish bylaws, policies, and procedures governing the operations of MNsure in accordance with this chapter.

Subd. 2. **Operations funding.** (a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(c) Beginning January 1, 2016, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(d) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.

(e) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

Subd. 3. **Insurance producers.** (a) By April 30, 2013, the board, in consultation with the commissioner of commerce, shall establish certification requirements that must be met by insurance producers in order to assist individuals and small employers with purchasing coverage through MNsure. Prior to January 1, 2015, the board may amend the requirements, only if necessary, due to a change in federal rules.

(b) Certification requirements shall not exceed the requirements established under Code of Federal Regulations, title 45, part 155.220. Certification shall include training on health plans available through MNsure, available tax credits and cost-sharing arrangements, compliance with privacy and security standards, eligibility verification processes, online enrollment tools, and basic information on available public health care programs. Training required for certification under this subdivision shall qualify for continuing education requirements for insurance producers required under chapter 60K, and must comply with course approval requirements under chapter 45.

(c) Producer compensation shall be established by health carriers that provide health plans through MNsure. The structure of compensation to insurance producers must be similar for health plans sold through MNsure and outside MNsure.

(d) Any insurance producer compensation structure established by a health carrier for the small group market must include compensation for defined contribution plans that involve multiple health carriers. The compensation offered must be commensurate with other small group market defined health plans.

(e) Any insurance producer assisting an individual or small employer with purchasing coverage through MNsure must disclose, orally and in writing, to the individual or small employer at the time of the first solicitation with the prospective purchaser the following:

(1) the health carriers and qualified health plans offered through MNsure that the producer is authorized to sell, and that the producer may not be authorized to sell all the qualified health plans offered through MNsure;

(2) that the producer may be receiving compensation from a health carrier for enrolling the individual or small employer into a particular health plan; and

(3) that information on all qualified health plans offered through MNsure is available through the MNsure Web site.

For purposes of this paragraph, "solicitation" means any contact by a producer, or any person acting on behalf of a producer made for the purpose of selling or attempting to sell coverage through MNsure. If the first solicitation is made by telephone, the disclosures required under this paragraph need not be made in writing, but the fact that disclosure has been made must be acknowledged on the application.

(f) Beginning January 15, 2015, each health carrier that offers or sells qualified health plans through MNsure shall report in writing to the board and the commissioner of commerce the compensation and other incentives it offers or provides to insurance producers with regard to each type of health plan the health carrier offers or sells both inside and outside of MNsure. Each health carrier shall submit a report annually and upon any change to the compensation or other incentives offered or provided to insurance producers.

(g) Nothing in this chapter shall prohibit an insurance producer from offering professional advice and recommendations to a small group purchaser based upon information provided to the producer.

(h) An insurance producer that offers health plans in the small group market shall notify each small group purchaser of which group health plans qualify for Internal Revenue Service approved section 125 tax benefits. The insurance producer shall also notify small group purchasers of state law provisions that benefit small group plans when the employer agrees to pay 50 percent or more of its employees' premium. Individuals who are eligible for cost-effective medical assistance will count toward the 75 percent participation requirement in section 62L.03, subdivision 3.

(i) Nothing in this subdivision shall be construed to limit the licensure requirements or regulatory functions of the commissioner of commerce under chapter 60K.

Subd. 4. **Navigator; in-person assisters; call center.** (a) The board shall establish policies and procedures for the ongoing operation of a navigator program, in-person assister program, call center, and customer service provisions for MNsure to be implemented beginning January 1, 2015.

(b) Until the implementation of the policies and procedures described in paragraph (a), the following shall be in effect:

(1) the navigator program shall be met by section 256.962;

(2) entities eligible to be navigators, including entities defined in Code of Federal Regulations, title 45, part 155.210 (c)(2), may serve as in-person assisters;

(3) the board shall establish requirements and compensation for the navigator program and the in-person assister program by April 30, 2013. Compensation for navigators and in-person assisters must take into account any other compensation received by the navigator or in-person assister for conducting the same or similar services; and

(4) call center operations shall utilize existing state resources and personnel, including referrals to counties for medical assistance.

(c) The board shall establish a toll-free number for MNsure and may hire and contract for additional resources as deemed necessary.

(d) The navigator program and in-person assister program must meet the requirements of section 1311(i) of the Affordable Care Act, Public Law 111-148. In establishing training standards for the navigators and in-person assisters, the board must ensure that all entities and individuals carrying out navigator and in-person assister functions have training in the needs of underserved and vulnerable populations; eligibility and enrollment rules and procedures; the range of available public health care programs and qualified health plan options offered through MNsure; and privacy and security standards. For calendar year 2014, the commissioner of human services shall ensure that the navigator program under section 256.962 provides application assistance for both qualified health plans offered through MNsure and public health care programs.

(e) The board must ensure that any information provided by navigators, in-person assisters, the call center, or other customer assistance portals be accessible to persons with disabilities and that information provided on public health care programs include information on other coverage options available to persons with disabilities.

Subd. 5. **Health carrier and health plan requirements; participation.** (a) Beginning January 1, 2015, the board may establish certification requirements for health carriers and health

plans to be offered through MNsure that satisfy federal requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory requirements that:

(1) apply uniformly to all health carriers and health plans in the individual market;

(2) apply uniformly to all health carriers and health plans in the small group market; and

(3) satisfy minimum federal certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(c) In accordance with section 1311(e) of the Affordable Care Act, Public Law 111-148, the board shall establish policies and procedures for certification and selection of health plans to be offered as qualified health plans through MNsure. The board shall certify and select a health plan as a qualified health plan to be offered through MNsure, if:

(1) the health plan meets the minimum certification requirements established in paragraph (a) or the market regulatory requirements in paragraph (b);

(2) the board determines that making the health plan available through MNsure is in the interest of qualified individuals and qualified employers;

(3) the health carrier applying to offer the health plan through MNsure also applies to offer health plans at each actuarial value level and service area that the health carrier currently offers in the individual and small group markets; and

(4) the health carrier does not apply to offer health plans in the individual and small group markets through MNsure under a separate license of a parent organization or holding company under section 60D.15, that is different from what the health carrier offers in the individual and small group markets outside MNsure.

(d) In determining the interests of qualified individuals and employers under paragraph (c), clause (2), the board may not exclude a health plan for any reason specified under section 1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148. The board may consider:

(1) affordability;

(2) quality and value of health plans;

(3) promotion of prevention and wellness;

(4) promotion of initiatives to reduce health disparities;

(5) market stability and adverse selection;

(6) meaningful choices and access;

(7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and

(8) other criteria that the board determines appropriate.

(e) For qualified health plans offered through MNsure on or after January 1, 2015, the board shall establish policies and procedures under paragraphs (c) and (d) for selection of health plans to be offered as qualified health plans through MNsure by February 1 of each year, beginning February 1, 2014. The board shall consistently and uniformly apply all policies and procedures and any requirements, standards, or criteria to all health carriers and health plans. For any policies, procedures, requirements, standards, or criteria that are defined as rules under section 14.02, subdivision 4, the board may use the process described in subdivision 9.

(f) For 2014, the board shall not have the power to select health carriers and health plans for participation in MNsure. The board shall permit all health plans that meet the certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, to be offered through MNsure.

(g) Under this subdivision, the board shall have the power to verify that health carriers and health plans are properly certified to be eligible for participation in MNsure.

(h) The board has the authority to decertify health carriers and health plans that fail to maintain compliance with section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(i) For qualified health plans offered through MNsure beginning January 1, 2015, health carriers must use the most current addendum for Indian health care providers approved by the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with Indian health care providers. MNsure shall comply with all future changes in federal law with regard to health coverage for the tribes.

Subd. 6. **Appeals.** (a) The board may conduct hearings, appoint hearing officers, and recommend final orders related to appeals of any MNsure determinations, except for those determinations identified in paragraph (d). An appeal by a health carrier regarding a specific certification or selection determination made by MNsure under subdivision 5 must be conducted as a contested case proceeding under chapter 14, with the report or order of the administrative law judge constituting the final decision in the case, subject to judicial review under sections 14.63 to 14.69. For other appeals, the board shall establish hearing processes which provide for a

reasonable opportunity to be heard and timely resolution of the appeal and which are consistent with the requirements of federal law and guidance. An appealing party may be represented by legal counsel at these hearings, but this is not a requirement.

(b) MNsure may establish service-level agreements with state agencies to conduct hearings for appeals. Notwithstanding section 471.59, subdivision 1, a state agency is authorized to enter into service-level agreements for this purpose with MNsure.

(c) For proceedings under this subdivision, MNsure may be represented by an attorney who is an employee of MNsure.

(d) This subdivision does not apply to appeals of determinations where a state agency hearing is available under section 256.045.

Subd. 7. **Agreements; consultation.** (a) The board shall:

(1) establish and maintain an agreement with the chief information officer of the Office of MN.IT Services for information technology services that ensures coordination with public health care programs. The board may establish and maintain agreements with the chief information officer of the Office of MN.IT Services for other information technology services, including an agreement that would permit MNsure to administer eligibility for additional health care and public assistance programs under the authority of the commissioner of human services;

(2) establish and maintain an agreement with the commissioner of human services for cost allocation and services regarding eligibility determinations and enrollment for public health care programs that use a modified adjusted gross income standard to determine program eligibility. The board may establish and maintain an agreement with the commissioner of human services for other services;

(3) establish and maintain an agreement with the commissioners of commerce and health for services regarding enforcement of MNsure certification requirements for health plans and dental plans offered through MNsure. The board may establish and maintain agreements with the commissioners of commerce and health for other services; and

(4) establish interagency agreements to transfer funds to other state agencies for their costs related to implementing and operating MNsure, excluding medical assistance allocatable costs.

(b) The board shall consult with the commissioners of commerce and health regarding the operations of MNsure.

(c) The board shall consult with Indian tribes and organizations regarding the operation of MNsure.

(d) Beginning March 15, 2014, and each March 15 thereafter, the board shall submit a report to the chairs and ranking minority members of the committees in the senate and house of representatives with primary jurisdiction over commerce, health, and human services on all the agreements entered into with the chief information officer of the Office of MN.IT Services, or the commissioners of human services, health, or commerce in accordance with this subdivision. The report shall include the agency in which the agreement is with; the time period of the agreement; the purpose of the agreement; and a summary of the terms of the agreement. A copy of the agreement must be submitted to the extent practicable.

Subd. 8. **Rulemaking.** (a) If the board's policies, procedures, or other statements are rules, as defined in section 14.02, subdivision 4, the requirements in either paragraph (b) or (c) apply, as applicable.

(b) Effective upon enactment until January 1, 2015:

(1) the board shall publish notice of proposed rules in the State Register after complying with section 14.07, subdivision 2;

(2) interested parties have 21 days to comment on the proposed rules. The board must consider comments it receives. After the board has considered all comments and has complied with section 14.07, subdivision 2, the board shall publish notice of the final rule in the State Register;

(3) if the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules that differ from the proposed rules shall be included in the notice of adoption, together with a citation to the prior State Register that contained the notice of the proposed rules; and

(4) rules published in the State Register before January 1, 2014, take effect upon publication of the notice. Rules published in the State Register on and after January 1, 2014, take effect 30 days after publication of the notice.

(c) Beginning January 1, 2015, the board may adopt rules to implement any provisions in this chapter using the expedited rulemaking process in section 14.389.

(d) The notice of proposed rules required in paragraph (b) must provide information as to where the public may obtain a copy of the rules. The board shall post the proposed rules on the MNsure Web site at the same time the notice is published in the State Register.

Subd. 9. **Dental plans.** (a) The provisions of this section that apply to health plans shall apply to dental plans offered as stand-alone dental plans through MNsure, to the extent practicable.

(b) A stand-alone dental plan offered through MNsure must meet all certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, that are applicable to health plans, except for certification requirements that cannot be met because the dental plan only covers dental benefits.

Subd. 10. **Limitations; risk-bearing.** (a) The board shall not bear insurance risk or enter into any agreement with health care providers to pay claims.

(b) Nothing in this subdivision shall prevent MNsure from providing insurance for its employees.

62V.06 DATA PRACTICES.

Subdivision 1. **Applicability.** MNsure is a state agency for purposes of the Minnesota Government Data Practices Act and is subject to all provisions of chapter 13, in addition to the requirements contained in this section.

Subd. 2. **Definitions.** As used in this section:

(1) "individual" means an individual according to section 13.02, subdivision 8, but does not include a vendor of services; and

(2) "participating" means that an individual, employee, or employer is seeking, or has sought an eligibility determination, enrollment processing, or premium processing through MNsure.

Subd. 3. **General data classifications.** The following data collected, created, or maintained by MNsure are classified as private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9:

(1) data on any individual participating in MNsure;

(2) data on any individuals participating in MNsure as employees of an employer participating in MNsure; and

(3) data on employers participating in MNsure.

Subd. 4. **Application and certification data.** (a) Data submitted by an insurance producer in an application for certification to sell a health plan through MNsure, or submitted by an applicant seeking permission or a commission to act as a navigator or in-person assister, are classified as follows:

(1) at the time the application is submitted, all data contained in the application are private data, as defined in section 13.02, subdivision 12, or nonpublic data as defined in section 13.02, subdivision 9, except that the name of the applicant is public; and

(2) upon a final determination related to the application for certification by MNsure, all data contained in the application are public, with the exception of trade secret data as defined in section 13.37.

(b) Data created or maintained by a government entity as part of the evaluation of an application are protected nonpublic data, as defined in section 13.02, subdivision 13, until a final determination as to certification is made and all rights of appeal have been exhausted. Upon a final determination and exhaustion of all rights of appeal, these data are public, with the exception of trade secret data as defined in section 13.37 and data subject to attorney-client privilege or other protection as provided in section 13.393.

(c) If an application is denied, the public data must include the criteria used by the board to evaluate the application and the specific reasons for the denial, and these data must be published on the MNsure Web site.

Subd. 5. **Data sharing.** (a) MNsure may share or disseminate data classified as private or nonpublic in subdivision 3 as follows:

(1) to the subject of the data, as provided in section 13.04;

(2) according to a court order;

(3) according to a state or federal law specifically authorizing access to the data;

(4) with other state or federal agencies, only to the extent necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to an individual, employer, or employee participating in MNsure, provided that MNsure must enter into a data-sharing agreement with the agency prior to sharing data under this clause; and

(5) with a nongovernmental person or entity, only to the extent necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to an individual, employer, or employee participating in MNsure, provided that MNsure must enter into a contract with the person or entity, as provided in section 13.05, subdivision 6 or 11, prior to disseminating data under this clause.

(b) MNsure may share or disseminate data classified as private or nonpublic in subdivision 4 as follows:

(1) to the subject of the data, as provided in section 13.04;

(2) according to a court order;

(3) according to a state or federal law specifically authorizing access to the data;

(4) with other state or federal agencies, only to the extent necessary to carry out the functions of MNsure, provided that MNsure must enter into a data-sharing agreement with the agency prior to sharing data under this clause; and

(5) with a nongovernmental person or entity, only to the extent necessary to carry out the functions of MNsure, provided that MNsure must enter a contract with the person or entity, as provided in section 13.05, subdivision 6 or 11, prior to disseminating data under this clause.

(c) Sharing or disseminating data outside of MNsure in a manner not authorized by this subdivision is prohibited. The list of authorized dissemination and sharing contained in this subdivision must be included in the Tennessen warning required by section 13.04, subdivision 2.

(d) Until July 1, 2014, state agencies must share data classified as private or nonpublic on individuals, employees, or employers participating in MNsure with MNsure, only to the extent such data are necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to a MNsure participant. The agency must enter into a data-sharing agreement with MNsure prior to sharing any data under this paragraph.

Subd. 6. **Notice and disclosures.** (a) In addition to the Tennessen warning required by section 13.04, subdivision 2, MNsure must provide any data subject asked to supply private data with:

(1) a notice of rights related to the handling of genetic information, pursuant to section 13.386; and

(2) a notice of the records retention policy of MNsure, detailing the length of time MNsure will retain data on the individual and the manner in which it will be destroyed upon expiration of that time.

(b) All notices required by this subdivision, including the Tennessen warning, must be provided in an electronic format suitable for downloading or printing.

Subd. 7. **Summary data.** In addition to creation and disclosure of summary data derived from private data on individuals, as permitted by section 13.05, subdivision 7, MNsure may create and disclose summary data derived from data classified as nonpublic under this section.

Subd. 8. **Access to data; audit trail.** (a) Only individuals with explicit authorization from the board may enter, update, or access not public data collected, created, or maintained by MNsure. The ability of authorized individuals to enter, update, or access data must be limited through the use of role-based access that corresponds to the official duties or training level of the individual, and the statutory authorization that grants access for that purpose. All queries and responses, and all actions in which data are entered, updated, accessed, or shared or disseminated outside of MNsure, must be recorded in a data audit trail. Data contained in the audit trail are public, to the extent that the data are not otherwise classified by this section.

The board shall immediately and permanently revoke the authorization of any individual determined to have willfully entered, updated, accessed, shared, or disseminated data in violation of this section, or any provision of chapter 13. If an individual is determined to have willfully gained access to data without explicit authorization from the board, the board shall forward the matter to the county attorney for prosecution.

(b) This subdivision shall not limit or affect the authority of the legislative auditor to access data needed to conduct audits, evaluations, or investigations of MNsure or the obligation of the board and MNsure employees to comply with section 3.978, subdivision 2.

(c) This subdivision does not apply to actions taken by a MNsure participant to enter, update, or access data held by MNsure, if the participant is the subject of the data that is entered, updated, or accessed.

Subd. 9. **Sale of data prohibited.** MNsure may not sell any data collected, created, or maintained by MNsure, regardless of its classification, for commercial or any other purposes.

Subd. 10. **Gun and firearm ownership.** MNsure shall not collect information that indicates whether or not an individual owns a gun or has a firearm in the individual's home.

62V.07 FUNDS.

(a) The MNsure account is created in the special revenue fund of the state treasury. All funds received by MNsure shall be deposited in the account. Funds in the account are appropriated to MNsure for the operation of MNsure. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the MNsure account not currently needed, shall be credited to the MNsure account.

(b) The budget submitted to the legislature under section 16A.11 must include budget information for MNsure.

62V.08 REPORTS.

(a) MNsure shall submit a report to the legislature by January 15, 2015, and each January 15 thereafter, on: (1) the performance of MNsure operations; (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4) practices and procedures that have been implemented to ensure compliance with data practices laws, and a description of any violations of data practices laws or procedures; and (5) the effectiveness of the outreach and implementation activities of MNsure in reducing the rate of uninsurance.

(b) MNsure must publish its administrative and operational costs on a Web site to educate consumers on those costs. The information published must include: (1) the amount of premiums and federal premium subsidies collected; (2) the amount and source of revenue received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and source of any other fees collected for purposes of supporting operations; and (4) any misuse of funds as identified in accordance with section 3.975. The Web site must be updated at least annually.

62V.09 EXPIRATION AND SUNSET EXCLUSION.

Notwithstanding section 15.059, the board and its advisory committees shall not expire, except as specified in section 62V.04, subdivision 13. The board and its advisory committees are not subject to review or sunsetting under chapter 3D.

62V.10 RIGHT NOT TO PARTICIPATE.

Nothing in this chapter infringes on the right of a Minnesota citizen not to participate in MNsure.

62V.11 LEGISLATIVE OVERSIGHT COMMITTEE.

Subdivision 1. **Legislative oversight.** (a) The Legislative Oversight Committee is established to provide oversight to the implementation of this chapter and the operation of MNsure.

(b) The committee shall review the operations of MNsure at least annually and shall recommend necessary changes in policy, implementation, and statutes to the board and to the legislature.

(c) MNsure shall present to the committee the annual report required in section 62V.08, the appeals process under section 62V.05, subdivision 6, and the actions taken regarding the treatment of multiemployer plans.

Subd. 2. **Membership; meetings; compensation.** (a) The Legislative Oversight Committee shall consist of five members of the senate, three members appointed by the majority leader of the senate, and two members appointed by the minority leader of the senate; and five members of the house of representatives, three members appointed by the speaker of the house, and two members appointed by the minority leader of the house of representatives.

(b) Appointed legislative members serve at the pleasure of the appointing authority and shall continue to serve until their successors are appointed.

(c) The first meeting of the committee shall be convened by the chair of the Legislative Coordinating Commission. Members shall elect a chair at the first meeting. The chair must convene at least one meeting annually, and may convene other meetings as deemed necessary.

Subd. 3. **Review of proposed rules.** (a) Prior to the implementation of rules proposed under section 62V.05, subdivision 8, paragraph (b), the board shall submit the proposed rules to the committee at the same time the proposed rules are published in the State Register.

(b) When the legislature is in session, the rule may be adopted, but, if within ten days of receipt of the proposed rule a majority of the committee members appointed by the senate and a majority of the committee members appointed by the house of representatives request further review of the proposed rule, the rule shall not be effective until the request has been satisfied and withdrawn, the rule is approved in law, or the regular session of the legislature is adjourned for the year.

(c) If the legislature is not in session, the rule may be adopted, but, if within ten days of receipt of the proposed rule a majority of the committee members appointed by the senate and a majority of the committee members appointed by the house of representatives request further review of the proposed rule, the rule shall not be effective until the request has been satisfied and withdrawn, or February 1, whichever occurs first.

Subd. 4. **Review of costs.** The board shall submit for review the annual budget of MNsure for the next fiscal year by March 15 of each year, beginning March 15, 2014.

148.57 LICENSE.

Subd. 3. **Revocation, suspension.** The board may revoke the license or suspend or restrict the right to practice of any person who has been convicted of any violation of sections 148.52 to 148.62 or of any other criminal offense, or who violates any provision of sections 148.571 to 148.576 or who is found by the board to be incompetent or guilty of unprofessional conduct. "Unprofessional conduct" means any conduct of a character likely to deceive or defraud the public, including, among other things, free examination advertising, the loaning of a license by any licensed optometrist to any person; the employment of "cappers" or "steerers" to obtain business; splitting or dividing a fee with any person; the obtaining of any fee or compensation by fraud or misrepresentation; employing directly or indirectly any suspended or unlicensed optometrist to perform any work covered by sections 148.52 to 148.62; the advertising by any means of optometric practice or treatment or advice in which untruthful, improbable, misleading, or impossible statements are made. After one year, upon application and proof that the disqualification has ceased, the board may reinstate such person.

Subd. 4. **Peddling or canvassing forbidden.** Every licensed optometrist who shall temporarily practice optometry outside or away from the regular registered place of business shall display the license and deliver to each customer or person there fitted or supplied with glasses a receipt or record which shall contain the signature, permanent registered place of business or post office address, and number of license of the optometrist, together with the amount charged therefor, but nothing contained in this section shall be construed as to permit peddling or canvassing by licensed optometrists.

148.571 USE OF TOPICAL OCULAR DRUGS.

Subdivision 1. **Authority.** Subject to the provisions of sections 148.571 to 148.574, optometrists who are currently licensed on August 1, 2007, and are not board certified under section 148.575 may possess a valid topical ocular drug certificate, referred to in sections 148.571 to 148.574, allowing them to administer topical ocular drugs to the anterior segment of the human eye during an eye examination in the course of practice in their normal practice setting, solely for the purposes of determining the refractive, muscular, or functional origin of sources of visual discomfort or difficulty, and detecting abnormalities which may be evidence of disease. Authority granted under sections 148.571 to 148.574 is granted to optometrists who are board certified under section 148.575.

Subd. 2. **Drugs specified.** For purposes of sections 148.571 to 148.574, "topical ocular drugs" means:

(1) commercially prepared topical anesthetics as follows: proparacaine HC1 0.5 percent, tetracaine HC1 0.5 percent, and benoxinate HC1 0.4 percent;

(2) commercially prepared mydriatics as follows: phenylephrine HC1 in strength not greater than 2.5 percent and hydroxyamphetamine HBr in strength not greater than 1 percent; and

(3) commercially prepared cycloplegics/mydriatics as follows: tropicamide in strength not greater than 1 percent and cyclopentolate in strength not greater than 1 percent.

148.572 ADVICE TO SEEK DIAGNOSIS AND TREATMENT.

Whether or not topical ocular drugs have been used, if any licensed optometrist is informed by a patient or determines from examining a patient, using judgment and that degree of skill, care, knowledge and attention ordinarily possessed and exercised by optometrists in good standing under like circumstances, that there are present in that patient signs or symptoms which

may be evidence of disease that requires treatment that is beyond the practice of optometry permitted by law, then the licensed optometrist shall (1) promptly advise that patient to seek evaluation by an appropriate licensed physician for diagnosis and possible treatment and (2) not attempt to treat such condition by the use of drugs or any other means.

148.573 TOPICAL OCULAR DRUG USE.

Subdivision 1. **Certificate required.** A licensed optometrist shall not purchase, possess or administer any topical ocular drugs unless the optometrist has obtained a topical ocular drug certificate from the Board of Optometry certifying that the optometrist has complied with the requirements in paragraphs (a) and (b).

(a) Successful completion of 60 classroom hours of study in general and clinical pharmacology as it relates to the practice of optometry, with particular emphasis on the use of topical ocular drugs for examination purposes. At least 30 of the 60 classroom hours shall be in ocular pharmacology and shall emphasize the systemic effects of and reactions to topical ocular drugs, including the emergency management and referral of any adverse reactions that may occur. The course of study shall be approved by the Board of Optometry, and shall be offered by an institution which is accredited by a regional or professional accreditation organization recognized or approved by the Council on Postsecondary Education or the United States Department of Education or their successors. The course shall be completed prior to entering the examination required by this section.

(b) Successful completion of an examination approved by the Board of Optometry on the subject of general and ocular pharmacology as it relates to optometry with particular emphasis on the use of topical ocular drugs, including emergency management and referral of any adverse reactions that may occur.

148.575 CERTIFICATE REQUIRED FOR USE OF TOPICAL LEGEND DRUGS.

Subdivision 1. **Certificate required for use of legend drugs.** A licensed optometrist must be board certified to use legend drugs for therapy under section 148.576.

Subd. 3. **Display of certificate required.** A certificate issued under this section to a licensed optometrist by the Board of Optometry supersedes any previously issued certificate limited to topical ocular drugs described in sections 148.571 to 148.574 and must be displayed in a prominent place in the licensed optometrist's office.

Subd. 5. **Notice to Board of Pharmacy.** The Board of Optometry shall notify the Board of Pharmacy of each licensed optometrist who meets the certification requirements in this section.

Subd. 6. **Board certification required.** Optometrists who were licensed in this state prior to August 1, 2007, must have met the board certification requirements under this section by August 1, 2012, in order to renew their license.

148.576 USE OF LEGEND DRUGS; LIMITATIONS; REPORTS.

Subdivision 1. **Authority to prescribe or administer.** A licensed optometrist who is board certified under section 148.575 may prescribe or administer legend drugs to aid in the diagnosis, cure, mitigation, prevention, treatment, or management of disease, deficiency, deformity, or abnormality of the human eye and adnexa included in the curricula of accredited schools or colleges of optometry. Nothing in this section shall allow (1) legend drugs to be administered intravenously, intramuscularly, or by injection except for treatment of anaphylaxis, (2) invasive surgery including, but not limited to, surgery using lasers, (3) Schedule II and III oral legend drugs and oral steroids to be administered or prescribed, (4) oral antivirals to be prescribed or administered for more than ten days, or (5) oral carbonic anhydrase inhibitors to be prescribed or administered for more than seven days.

Subd. 2. **Adverse reaction reports.** An optometrist certified to prescribe legend drugs shall file with the Board of Optometry within ten working days of its occurrence a report on any adverse reaction resulting from the optometrist's administration of a drug. The report must include the optometrist's name, address, and license number; the patient's name, address, and age; the patient's presenting problem; the diagnosis; the agent administered and the method of administration; the reaction; and the subsequent action taken.

148E.060 TEMPORARY LICENSES.

Subd. 12. **Ineligibility.** An applicant who is currently practicing social work in Minnesota in a setting that is not exempt under section 148E.065 at the time of application is ineligible for a temporary license.

148E.075 INACTIVE LICENSES.

Subd. 4. **Time limits for temporary leaves.** A licensee may maintain an inactive license on temporary leave for no more than five consecutive years. If a licensee does not apply for reactivation within 60 days following the end of the consecutive five-year period, the license automatically expires.

Subd. 5. **Time limits for emeritus license.** A licensee with an emeritus license may not apply for reactivation according to section 148E.080 after five years following the granting of the emeritus license. However, after five years following the granting of the emeritus license, an individual may apply for new licensure according to section 148E.055.

Subd. 6. **Prohibition on practice.** (a) Except as provided in paragraph (b), a licensee whose license is inactive must not practice, attempt to practice, offer to practice, or advertise or hold out as authorized to practice social work.

(b) The board may grant a variance to the requirements of paragraph (a) if a licensee on inactive status provides emergency social work services. A variance is granted only if the board provides the variance in writing to the licensee. The board may impose conditions or restrictions on the variance.

Subd. 7. **Representations of professional status.** In making representations of professional status to the public, a licensee whose license is inactive must state that the license is inactive and that the licensee cannot practice social work.

214.105 HEALTH-RELATED LICENSING BOARDS; DEFAULT ON FEDERAL LOANS OR SERVICE OBLIGATIONS.

A health-related licensing board may refuse to grant a license or may impose disciplinary action against a person regulated by the board if the person is intentionally in nonpayment, default, or breach of a repayment or service obligation under any federal educational loan, loan repayment, or service conditional scholarship program. The board shall consider the reasons for nonpayment, default, or breach of a repayment or service obligation and may not impose disciplinary action against a person in cases of total and permanent disability or long-term temporary disability lasting more than a year.

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 35. **Federal approval.** (a) The commissioner shall seek federal authority from the U.S. Department of Health and Human Services necessary to operate a health coverage program for Minnesotans with incomes up to 275 percent of the federal poverty guidelines (FPG). The proposal shall seek to secure all federal funding available from at least the following sources:

(1) all premium tax credits and cost sharing subsidies available under United States Code, title 26, section 36B, and United States Code, title 42, section 18071, for individuals with incomes above 133 percent and at or below 275 percent of the federal poverty guidelines who would otherwise be enrolled in MNsure as defined in section 62V.02;

(2) Medicaid funding; and

(3) other funding sources identified by the commissioner that support coverage or care redesign in Minnesota.

(b) Funding received shall be used to design and implement a health coverage program that creates a single streamlined program and meets the needs of Minnesotans with incomes up to 275 percent of the federal poverty guidelines. The program must incorporate:

(1) payment reform characteristics included in the health care delivery system and accountable care organization payment models;

(2) flexibility in benefit set design such that benefits can be targeted to meet enrollee needs in different income and health status situations and can provide a more seamless transition from public to private health care coverage;

(3) flexibility in co-payment or premium structures to incent patients to seek high-quality, low-cost care settings; and

(4) flexibility in premium structures to ease the transition from public to private health care coverage.

(c) The commissioner shall develop and submit a proposal consistent with the above criteria and shall seek all federal authority necessary to implement the health coverage program.

In developing the request, the commissioner shall consult with appropriate stakeholder groups and consumers.

(d) The commissioner is authorized to seek any available waivers or federal approvals to accomplish the goals under paragraph (b) prior to 2017.

(e) The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing by January 15, 2015, on the progress of receiving a federal waiver and shall make recommendations on any legislative changes necessary to accomplish the project in this subdivision. Any implementation of the waiver that requires a state financial contribution to operate a health coverage program for Minnesotans with incomes between 200 and 275 percent of the federal poverty guidelines, shall be contingent on legislative action approving the contribution.

(f) The commissioner is authorized to accept and expend federal funds that support the purposes of this subdivision.

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subd. 19b. **Nursing facility rate adjustments beginning October 1, 2015.** A total of a 3.2 percent average rate adjustment shall be provided as described under this subdivision and under section 256B.441, subdivision 46c.

(a) Beginning October 1, 2015, the commissioner shall make available to each nursing facility reimbursed under this section a 2.4 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) The commissioner shall allow as compensation-related costs all costs for:

(1) wage and salary increases effective after May 25, 2015;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective October 1, 2015. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(e) The commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:

(1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct-care employees;

(2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2015, and prior to April 1, 2016; and

(3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2015.

Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this subdivision have been met. The rate adjustment shall be effective October 1, 2015. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

(g) The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on September 30, 2015. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256B.441, subdivision 55a, critical access nursing facility program participation under section 256B.441, subdivision 63, or performance-based incentive payment program participation under subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on September 30, 2015.

256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.

Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups, called "facility type groups," which shall consist of:

(1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3400; and

(2) freestanding: all other facilities.

Subd. 19. **Hospital-attached nursing facility status.** (a) For the purpose of setting rates under this section, for rate years beginning after September 30, 2006, "hospital-attached nursing facility" means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. Direct identification of costs to the nursing facility cost center will be permitted only when the

comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

Subd. 50a. **Determination of proximity adjustments.** (a) For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

(b) Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route.

Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of $3.

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

Subd. 58. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits under subdivision 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under subdivision 53, the commissioner shall compare the average operating cost for all facilities combined from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost. The rebasing of property payment rates under subdivision 1, and the removal of planned closure rate adjustments and single-bed room incentives from external fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating payment rate from this section is phased in as described in subdivision 55.

Subd. 62. **Repeal of rebased operating payment rates.** Notwithstanding subdivision 54 or 55, no further steps toward phase-in of rebased operating payment rates shall be taken.

256D.0513 BUDGETING LUMP SUMS.

Effective January 1, 1998, nonrecurring lump-sum income received by a recipient of general assistance must be budgeted in the normal retrospective cycle.

256D.06 AMOUNT OF ASSISTANCE.

Subd. 8. **Recovery of ATM errors.** For recipients receiving benefits via electronic benefit transfer, if the recipient is overpaid as a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

256D.09 PAYMENT; ASSESSMENT; OVERPAYMENT.

Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or family general assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) Except as provided for interim assistance in section 256D.06, subdivision 5, when an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member, for one or more monthly assistance payments, until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent where fraud has occurred, or the amount of the monthly payment, whichever is less, for all overpayments.

(c) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(d) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions provided in this subdivision, to include further voluntary reductions

in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(e) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance under standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

(f) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error and six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

256D.49 PAYMENT CORRECTION.

Subdivision 1. **When.** When the county agency finds that the recipient has received less than or more than the correct payment of Minnesota supplemental aid benefits, the county agency shall issue a corrective payment or initiate recovery under subdivision 3, as appropriate.

Subd. 2. **Underpayment of monthly grants.** When the county agency determines that an underpayment of the recipient's monthly payment has occurred, it shall, during that same month, issue a corrective payment. Corrective payments must be excluded when determining the applicant's or recipient's income and resources for the month of payment.

Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** (a) When the county agency determines that an overpayment of the recipient's monthly payment of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment to the recipient. If the person is no longer receiving Minnesota supplemental aid, the county agency may request voluntary repayment or pursue civil recovery. If the person is receiving Minnesota supplemental aid, the county agency shall recover the overpayment by withholding an amount equal to three percent of the standard of assistance for the recipient or the total amount of the monthly grant, whichever is less.

(b) Establishment of an overpayment is limited to 12 months from the date of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

(c) For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

(d) Residents of licensed residential facilities shall not have overpayments recovered from their personal needs allowance.

256J.38 CORRECTION OF OVERPAYMENTS AND UNDERPAYMENTS.

Subdivision 1. **Scope of overpayment.** (a) When a participant or former participant receives an overpayment due to agency, client, or ATM error, or due to assistance received while an appeal is pending and the participant or former participant is determined ineligible for assistance or for less assistance than was received, the county agency must recoup or recover the overpayment using the following methods:

(1) reconstruct each affected budget month and corresponding payment month;

(2) use the policies and procedures that were in effect for the payment month; and

(3) do not allow employment disregards in section 256J.21, subdivision 3 or 4, in the calculation of the overpayment when the unit has not reported within two calendar months following the end of the month in which the income was received.

(b) Establishment of an overpayment is limited to 12 months prior to the month of discovery due to agency error. Establishment of an overpayment is limited to six years prior to the month of discovery due to client error or an intentional program violation determined under section 256.046.

Subd. 2. **Notice of overpayment.** When a county agency discovers that a participant or former participant has received an overpayment for one or more months, the county agency must notify the participant or former participant of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the authority for citing the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the participant's or former participant's right to appeal. No limit applies to the period in which the county agency is required to recoup or recover an overpayment according to subdivisions 3 and 4.

Subd. 3. **Recovering overpayments.** A county agency must initiate efforts to recover overpayments paid to a former participant or caregiver. Caregivers, both parental and nonparental, and minor caregivers of an assistance unit at the time an overpayment occurs, whether receiving assistance or not, are jointly and individually liable for repayment of the overpayment. The county agency must request repayment from the former participants and caregivers. When an agreement for repayment is not completed within six months of the date of discovery or when there is a default on an agreement for repayment after six months, the county agency must initiate recovery consistent with chapter 270A, or section 541.05. When a person has been convicted of fraud under section 256.98, recovery must be sought regardless of the amount of overpayment. When an overpayment is less than $35, and is not the result of a fraud conviction under section 256.98, the county agency must not seek recovery under this subdivision. The county agency must retain information about all overpayments regardless of the amount. When an adult, adult caregiver, or minor caregiver reapplies for assistance, the overpayment must be recouped under subdivision 4.

Subd. 4. **Recouping overpayments from participants.** A participant may voluntarily repay, in part or in full, an overpayment even if assistance is reduced under this subdivision, until the total amount of the overpayment is repaid. When an overpayment occurs due to fraud, the county agency must recover from the overpaid assistance unit, including child only cases, ten percent of the applicable standard or the amount of the monthly assistance payment, whichever is less. When a nonfraud overpayment occurs, the county agency must recover from the overpaid assistance unit, including child only cases, three percent of the MFIP standard of need or the amount of the monthly assistance payment, whichever is less.

Subd. 5. **Recovering automatic teller machine errors.** For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an ATM dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

Subd. 6. **Scope of underpayments.** A county agency must issue a corrective payment for underpayments made to a participant or to a person who would be a participant if an agency or client error causing the underpayment had not occurred. Corrective payments are limited to 12 months prior to the month of discovery. The county agency must issue the corrective payment according to subdivision 8.

Subd. 7. **Identifying the underpayment.** An underpayment may be identified by a county agency, by a participant, by a former participant, or by a person who would be a participant except for agency or client error.

Subd. 8. **Issuing corrective payments.** A county agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment of the participant or by issuing a separate payment to a participant or former participant, or by reducing an existing overpayment balance. When an underpayment occurs in a payment month and is not identified until the next payment month or later, the county agency must first subtract the underpayment from any overpayment balance before issuing the corrective payment. The county agency must not apply an underpayment in a current payment month against an overpayment balance. When an underpayment in the current payment month is identified, the corrective payment must be issued within seven calendar days after the underpayment is identified.

Subd. 9. **Appeals.** A participant may appeal an underpayment, an overpayment, and a reduction in an assistance payment made to recoup the overpayment under subdivision 4. The participant's appeal of each issue must be timely under section 256.045. When an appeal based on the notice issued under subdivision 2 is not timely, the fact or the amount of that overpayment must not be considered as a part of a later appeal, including an appeal of a reduction in an assistance payment to recoup that overpayment.

256L.01 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of this chapter, the following terms shall have the meanings given them.

Subd. 1a. **Child.** "Child" means an individual under 21 years of age, including the unborn child of a pregnant woman, an emancipated minor, and an emancipated minor's spouse.

Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance or regulations issued under, these acts.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 3. **Eligible providers.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subd. 3a. **Family.** (a) "Family" has the meaning given for family and family size as defined in Code of Federal Regulations, title 26, section 1.36B-1.

(b) The term includes children who are temporarily absent from the household in settings such as schools, camps, or parenting time with noncustodial parents.

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1.

Subd. 6. **MNsure.** "MNsure" means the state health benefit exchange as defined in section 62V.02.

Subd. 7. **Participating entity.** "Participating entity" means a health carrier as defined in section 62A.01, subdivision 2; a county-based purchasing plan established under section 256B.692; an accountable care organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

256L.02 PROGRAM ADMINISTRATION.

Subdivision 1. **Purpose.** The MinnesotaCare program is established to promote access to appropriate health care services to assure healthy children and adults.

Subd. 2. **Commissioner's duties.** (a) The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all participating entities under contract with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services.

(b) A toll-free telephone number and Web site must be used to provide information about medical programs and to promote access to the covered services.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

Subd. 5. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments,

payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of management and budget, when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

(b) The commissioner of human services, in consultation with the commissioner of management and budget, shall work with the Centers for Medicare and Medicaid Services to establish a process for reconciliation and adjustment of federal payments that balances state and federal liability over time. The commissioner of human services shall request that the secretary of health and human services hold the state, and enrollees, harmless in the reconciliation process for the first three years, to allow the state to develop a statistically valid methodology for predicting enrollment trends and their net effect on federal payments.

Subd. 6. **Coordination with MNsure.** MinnesotaCare shall be considered a public health care program for purposes of chapter 62V.

256L.03 COVERED HEALTH SERVICES.

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, with the exception of special education services, home care nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services.

(b) No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

(c) Covered health services shall be expanded as provided in this section.

Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible for coverage of all services that are eligible for reimbursement under the medical assistance program according to chapter 256B, except that abortion services under MinnesotaCare shall be limited as provided under subdivision 1. Children are exempt from the provisions of subdivision 5, regarding co-payments. Children who are lawfully residing in the United States but who are not "qualified noncitizens" under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all services provided under the medical assistance program according to chapter 256B.

Subd. 1b. **Pregnant women; eligibility for full medical assistance services.** A pregnant woman enrolled in MinnesotaCare is eligible for coverage of all services provided under the medical assistance program according to chapter 256B retroactive to the date of conception. Co-payments totaling $30 or more, paid after the date of conception, shall be refunded.

Subd. 2. **Alcohol and drug dependency.** Beginning July 1, 1993, covered health services shall include individual outpatient treatment of alcohol or drug dependency by a qualified health professional or outpatient program.

Persons who may need chemical dependency services under the provisions of this chapter shall be assessed by a local agency as defined under section 254B.01, and under the assessment provisions of section 254A.03, subdivision 3. A local agency or managed care plan under contract with the Department of Human Services must place a person in need of chemical dependency services as provided in Minnesota Rules, parts 9530.6600 to 9530.6660. Persons who are recipients of medical benefits under the provisions of this chapter and who are financially eligible for consolidated chemical dependency treatment fund services provided under the provisions of chapter 254B shall receive chemical dependency treatment services under the provisions of chapter 254B only if:

(1) they have exhausted the chemical dependency benefits offered under this chapter; or

(2) an assessment indicates that they need a level of care not provided under the provisions of this chapter.

Recipients of covered health services under the children's health plan, as provided in Minnesota Statutes 1990, section 256.936, and as amended by Laws 1991, chapter 292, article 4, section 17, and recipients of covered health services enrolled in the children's health plan or the MinnesotaCare program after October 1, 1992, pursuant to Laws 1992, chapter 549, article 4, sections 5 and 17, are eligible to receive alcohol and drug dependency benefits under this subdivision.

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and

residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown.

(b) Admissions for inpatient hospital services paid for under section 256L.11, subdivision 3, must be certified as medically necessary in accordance with Minnesota Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

(1) all admissions must be certified, except those authorized under rules established under section 254A.03, subdivision 3, or approved under Medicare; and

(2) payment under section 256L.11, subdivision 3, shall be reduced by five percent for admissions for which certification is requested more than 30 days after the day of admission. The hospital may not seek payment from the enrollee for the amount of the payment reduction under this clause.

Subd. 3a. **Interpreter services.** Covered services include sign and spoken language interpreter services that assist an enrollee in obtaining covered health care services.

Subd. 3b. **Chiropractic services.** MinnesotaCare covers the following chiropractic services: medically necessary exams, manual manipulation of the spine, and x-rays.

Subd. 4. **Coordination with medical assistance.** The commissioner shall coordinate the provision of hospital inpatient services under the MinnesotaCare program with enrollee eligibility under the medical assistance spenddown.

Subd. 4a. **Loss ratio.** Health coverage provided through the MinnesotaCare program must have a medical loss ratio of at least 85 percent, as defined using the loss ratio methodology described in section 1001 of the Affordable Care Act.

Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in this subdivision, the MinnesotaCare benefit plan shall include the following cost-sharing requirements for all enrollees:

(1) $3 per prescription for adult enrollees;

(2) $25 for eyeglasses for adult enrollees;

(3) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(4) $6 for nonemergency visits to a hospital-based emergency room for services provided through December 31, 2010, and $3.50 effective January 1, 2011; and

(5) a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54.

(b) Paragraph (a) does not apply to children under the age of 21.

(c) Paragraph (a), clause (3), does not apply to mental health services.

(d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed care plans or county-based purchasing plans shall not be increased as a result of the reduction of the co-payments in paragraph (a), clause (4), effective January 1, 2011.

(e) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (5). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for covered health services, the agency shall have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence that necessitated the payment for the covered health services. All liens under this section shall be subject to the provisions of section 256.015. For purposes of this subdivision, "state agency" includes participating entities, under contract with the commissioner according to section 256L.121.

256L.04 ELIGIBLE PERSONS.

Subdivision 1. **Families with children.** Families with children with family income above 133 percent of the federal poverty guidelines and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18 shall apply unless otherwise specified. Children under age 19 with family income at or below 200 percent of the federal poverty guidelines and who are ineligible for medical assistance by sole reason of the application of federal household composition rules for medical assistance are eligible for MinnesotaCare.

Subd. 1a. **Social Security number required.** (a) Individuals and families applying for MinnesotaCare coverage must provide a Social Security number.

(b) The commissioner shall not deny eligibility to an otherwise eligible applicant who has applied for a Social Security number and is awaiting issuance of that Social Security number.

(c) Newborns enrolled under section 256L.05, subdivision 3, are exempt from the requirements of this subdivision.

(d) Individuals who refuse to provide a Social Security number because of well-established religious objections are exempt from the requirements of this subdivision. The term "well-established religious objections" has the meaning given in Code of Federal Regulations, title 42, section 435.910.

Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through MNsure under chapter 62V.

Subd. 2. **Third-party liability, paternity, and other medical support.** (a) To be eligible for MinnesotaCare, individuals and families must cooperate with the state agency to identify potentially liable third-party payers and assist the state in obtaining third-party payments. "Cooperation" includes, but is not limited to, complying with the notice requirements in section 256B.056, subdivision 9, identifying any third party who may be liable for care and services provided under MinnesotaCare to the enrollee, providing relevant information to assist the state in pursuing a potentially liable third party, and completing forms necessary to recover third-party payments.

(b) A parent, guardian, relative caretaker, or child enrolled in the MinnesotaCare program must cooperate with the Department of Human Services and the local agency in establishing the paternity of an enrolled child and in obtaining medical care support and payments for the child and any other person for whom the person can legally assign rights, in accordance with applicable laws and rules governing the medical assistance program. A child shall not be ineligible for or disenrolled from the MinnesotaCare program solely because the child's parent, relative caretaker, or guardian fails to cooperate in establishing paternity or obtaining medical support.

Subd. 2a. **Applications for other benefits.** To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days of notification.

Subd. 7. **Single adults and households with no children.** The definition of eligible persons includes all individuals and families with no children who have incomes that are above 133 percent and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size.

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program.

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009.

Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals who receive Supplemental Security Income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility. Enrollees who do not cooperate with medical assistance shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

(c) Counties that choose to become MinnesotaCare enrollment sites shall consider MinnesotaCare applications to also be applications for medical assistance.

(d) The commissioner shall redetermine provider payments made under MinnesotaCare to the appropriate medical assistance payments for those enrollees who subsequently become eligible for medical assistance.

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

Subd. 12. **Persons in detention.** An applicant or enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare, unless the applicant or enrollee is awaiting disposition of charges.

Subd. 13. **Families with relative caretakers, foster parents, or legal guardians.** Beginning January 1, 1999, in families that include a relative caretaker as defined in the medical assistance program, foster parent, or legal guardian, the relative caretaker, foster parent, or legal guardian may apply as a family or may apply separately for the children. If the caretaker applies separately for the children, only the children's income is counted and the provisions of subdivision 1, paragraph (b), do not apply. If the relative caretaker, foster parent, or legal guardian applies with the children, their income is included in the gross family income for determining eligibility and premium amount.

Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for medical assistance under chapter 256B are not eligible for MinnesotaCare under this section.

(b) The commissioner shall coordinate eligibility and coverage to ensure that individuals transitioning between medical assistance and MinnesotaCare have seamless eligibility and access to health care services.

256L.05 APPLICATION PROCEDURES.

Subdivision 1. **Application assistance and information availability.** (a) Applicants may submit applications online, in person, by mail, or by phone in accordance with the Affordable Care Act, and by any other means by which medical assistance applications may be submitted. Applicants may submit applications through MNsure or through the MinnesotaCare program. Applications and application assistance must be made available at provider offices, local human services agencies, school districts, public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches, community health offices, Women, Infants and Children (WIC) program sites, Head Start program sites, public housing councils, crisis nurseries, child care centers, early childhood education and preschool program sites, legal aid offices, and libraries, and at any other locations at which medical assistance applications must be made available. These sites may accept applications and forward the forms to the commissioner or local county human services agencies that choose to participate as an enrollment site. Otherwise, applicants may apply directly to the commissioner or to participating local county human services agencies.

(b) Application assistance must be available for applicants choosing to file an online application through MNsure.

Subd. 1a. **Person authorized to apply on applicant's behalf.** Beginning January 1, 1999, a family member who is age 18 or over or who is an authorized representative, as defined in the medical assistance program, may apply on an applicant's behalf.

Subd. 1b. **MinnesotaCare enrollment by county agencies.** Beginning September 1, 2006, county agencies shall enroll single adults and households with no children formerly enrolled in general assistance medical care in MinnesotaCare according to Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3. County agencies shall perform all duties necessary to administer the MinnesotaCare program ongoing for these enrollees, including the redetermination of MinnesotaCare eligibility at renewal.

Subd. 1c. **Open enrollment and streamlined application and enrollment process.**

Subd. 2. **Commissioner's duties.** The commissioner or county agency shall use electronic verification through MNsure as the primary method of income verification. If there is a discrepancy between reported income and electronically verified income, an individual may be

required to submit additional verification to the extent permitted under the Affordable Care Act. In addition, the commissioner shall perform random audits to verify reported income and eligibility. The commissioner may execute data sharing arrangements with the Department of Revenue and any other governmental agency in order to perform income verification related to eligibility and premium payment under the MinnesotaCare program.

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. The effective date of coverage for new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's modified adjusted gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(d) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (c), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.

Subd. 3a. **Renewal of eligibility.** (a) Beginning July 1, 2007, an enrollee's eligibility must be renewed every 12 months. The 12-month period begins in the month after the month the application is approved.

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. An enrollee must provide all the information needed to redetermine eligibility by the first day of the month that ends the eligibility period. The premium for the new period of eligibility must be received as provided in section 256L.06 in order for eligibility to continue.

(c) For children enrolled in MinnesotaCare, the first period of renewal begins the month the enrollee turns 21 years of age.

Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective date of coverage shall be the first day of the month following termination from medical assistance for families and individuals who are eligible for MinnesotaCare and who submitted a written request for retroactive MinnesotaCare coverage with a completed application within 30 days of the mailing of notification of termination from medical assistance. The applicant must provide all required verifications within 30 days of the written request for verification. For retroactive coverage, premiums must be paid in full for any retroactive month, current month, and next month within 30 days of the premium billing. This subdivision does not apply, and shall not be implemented by the commissioner, once eligibility determination for MinnesotaCare is conducted by the MNsure eligibility determination system.

Subd. 4. **Application processing.** The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the Department of Human Services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare.

Subd. 5. **Availability of private insurance.** The commissioner, in consultation with the commissioners of health and commerce, shall provide information regarding the availability of private health insurance coverage and the possibility of disenrollment under section 256L.07, subdivision 1, to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided upon initial enrollment and annually thereafter. The commissioner shall also include information regarding the availability of private health insurance coverage in the notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1.

Subd. 6. **Referral of veterans.** The commissioner shall ensure that all applicants for MinnesotaCare who identify themselves as veterans are referred to a county veterans service

officer for assistance in applying to the United States Department of Veterans Affairs for any veterans benefits for which they may be eligible.

256L.06 PREMIUM ADMINISTRATION.

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage that is affordable and provides minimum value as defined in Code of Federal Regulations, title 26, section 1.36B-2.

(b) This subdivision does not apply to a family or individual who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

Subd. 3. **Other health coverage.** (a) To be eligible, a family or individual must not have minimum essential health coverage, as defined by section 5000A of the Internal Revenue Code.

(b) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have minimum essential health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

Subd. 4. **Families with children in need of chemical dependency treatment.** Premiums for families with children when a parent has been determined to be in need of chemical dependency treatment pursuant to an assessment conducted by the county under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, who are eligible for MinnesotaCare under section 256L.04, subdivision 1, may be paid by the county of residence of the person in need of treatment for one year from the date the family is determined to be eligible or if the family is currently enrolled in MinnesotaCare from the date the person is determined to be in need of chemical dependency treatment. Upon renewal, the family is responsible for any premiums owed under section 256L.15. If the family is not currently enrolled in MinnesotaCare,

the local county human services agency shall determine whether the family appears to meet the eligibility requirements and shall assist the family in applying for the MinnesotaCare program.

256L.09 RESIDENCY.

Subdivision 1. **Findings and purpose.** The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the general assistance medical care program, the medical assistance program, and public and private charity care programs.

Subd. 2. **Residency requirement.** To be eligible for health coverage under the MinnesotaCare program, individuals and families with children must meet the residency requirements as provided by Code of Federal Regulations, title 42, section 435.403.

Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

(b) To be eligible as a permanent resident, an applicant must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address, through the use of evidence of residence described in section 256D.02, subdivision 12a, paragraph (b), clause (2);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

(c) A person who is temporarily absent from the state does not lose eligibility for MinnesotaCare. "Temporarily absent from the state" means the person is out of the state for a temporary purpose and intends to return when the purpose of the absence has been accomplished. A person is not temporarily absent from the state if another state has determined that the person is a resident for any purpose. If temporarily absent from the state, the person must follow the requirements of the health plan in which the person is enrolled to receive services.

Subd. 5. **Persons excluded as permanent residents.** An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

Subd. 6. **12-month preexisting exclusion.** If the 180-day requirement in subdivision 4, paragraph (b), clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month preexisting condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

Subd. 7. **Effect of a court determination.** If any paragraph, sentence, clause, or phrase of this section is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the section. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this section, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

256L.10 APPEALS.

If the commissioner suspends, reduces, or terminates eligibility for the MinnesotaCare program, or services provided under the MinnesotaCare program, the commissioner must provide notification according to the laws and rules governing the medical assistance program. A

MinnesotaCare program applicant or enrollee aggrieved by a determination of the commissioner has the right to appeal the determination according to section 256.045.

256L.11 PROVIDER PAYMENT.

Subdivision 1. **Medical assistance rate to be used.** Payment to providers under this chapter shall be at the same rates and conditions established for medical assistance, except as provided in this section.

Subd. 2. **Payment of certain providers.** Services provided by federally qualified health centers, rural health clinics, and facilities of the Indian health service shall be paid for according to the same rates and conditions applicable to the same service provided by providers that are not federally qualified health centers, rural health clinics, or facilities of the Indian health service.

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under section 256L.03, subdivision 3, shall be at the medical assistance rate.

Subd. 4. **Definition of medical assistance rate for inpatient hospital services.** The "medical assistance rate," as used in this section to apply to rates for providing inpatient hospital services, means the rates established under sections 256.9685 to 256.9695 for providing inpatient hospital services to medical assistance recipients who receive Minnesota family investment program assistance.

Subd. 7. **Critical access dental providers.** Effective for dental services provided to MinnesotaCare enrollees on or after January 1, 2007, through August 31, 2011, the commissioner shall increase payment rates to dentists and dental clinics deemed by the commissioner to be critical access providers under section 256B.76, subdivision 4, by 50 percent above the payment rate that would otherwise be paid to the provider. Effective for dental services provided on or after September 1, 2011, the commissioner shall increase the payment rate by 30 percent above the payment rate that would otherwise be paid to the provider. The commissioner shall pay the prepaid health plans under contract with the commissioner amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate increase to providers who have been identified by the commissioner as critical access dental providers under section 256B.76, subdivision 4.

256L.12 MANAGED CARE.

Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans and managed care-like entities as defined by the final regulation implementing section 1331 of the Affordable Care Act regarding basic health plans, which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

Subd. 2. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. **Limitation of choice.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **Exemptions to limitations on choice.** All contracts between the Department of Human Services and prepaid health plans to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance will remain in the same managed care plan if the managed care plan has a contract for that population. MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all co-payments in section 256L.03, subdivision 5, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the Department of Human Services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee co-payments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care

services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do

not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Subd. 9b. **Rate setting; ratable reduction.** In addition to the reduction in subdivision 9a, the total payment made to managed care plans under the MinnesotaCare program shall be reduced for services provided on or after January 1, 2006, to reflect a 6.0 percent reduction in reimbursement for inpatient hospital services.

Subd. 10. **Childhood immunization.** Each managed care plan contracting with the Department of Human Services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

Subd. 11. **Coverage at Indian health service facilities.** For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian health service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Act, Public Law 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

256L.121 SERVICE DELIVERY.

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In counties that were part of a county-based purchasing plan on January 1, 2013, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, subdivisions 1 to 32, under which

selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

Subd. 2. **Other requirements for participating entities.** The commissioner shall require participating entities, as a condition of contract, to document to the commissioner:

(1) the provision of culturally and linguistically appropriate services, including marketing materials, to MinnesotaCare enrollees; and

(2) the inclusion in provider networks of providers designated as essential community providers under section 62Q.19.

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program;

(3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and 256B.694, when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; and

(5) establishing requirements and criteria for selection that ensure that covered health care services will be coordinated with local public health services, social services, long-term care services, mental health services, and other local services affecting enrollees' health, access, and quality of care.

256L.15 PREMIUMS.

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

(c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families shall have their premiums waived by the commissioner in accordance with section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

Subd. 1a. **Payment options.** The commissioner may offer the following payment options to an enrollee:

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

(5) payment by wage withholding with the consent of the employer and the employee; or

(6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the $10 fee under section 270A.07, subdivision 1.

Subd. 1b. **Payments nonrefundable.** Only MinnesotaCare premiums paid for future months of coverage for which a health plan capitation fee has not been paid may be refunded.

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the

MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (c) with the exception that children 20 years of age and younger in families with income at or below 200 percent of the federal poverty guidelines shall pay no premiums.

(c) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:

Federal Poverty Guideline Greater than or Equal to	Less than	Individual Premium Amount
0%	55%	$4
55%	80%	$6
80%	90%	$8
90%	100%	$10
100%	110%	$12
110%	120%	$15
120%	130%	$18
130%	140%	$21
140%	150%	$25
150%	160%	$29
160%	170%	$33
170%	180%	$38
180%	190%	$43
190%		$50

256L.18 PENALTIES.

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

(1) benefits under the MinnesotaCare program to which the person is not entitled; or

(2) benefits under the MinnesotaCare program greater than that to which the person is reasonably entitled;

shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided under that section.

256L.22 DEFINITION; CHILDREN'S HEALTH PROGRAM.

For purposes of sections 256L.22 to 256L.28, "children's health program" means the medical assistance and MinnesotaCare programs to the extent medical assistance and MinnesotaCare provide health coverage to children.

256L.24 HEALTH CARE ELIGIBILITY FOR CHILDREN.

Subdivision 1. **Applicability.** This section applies to children who are enrolled in a children's health program.

Subd. 2. **Application procedure.** The commissioner shall develop an application form for children's health programs for children that is easily understandable and does not exceed four pages in length. The provisions of section 256L.05, subdivision 1, apply.

Subd. 3. **Premiums.** Children enrolled in MinnesotaCare shall pay premiums as provided in section 256L.15.

Subd. 4. **Eligibility renewal.** The commissioner shall require children enrolled in MinnesotaCare to renew eligibility every 12 months.

256L.26 ASSISTANCE TO APPLICANTS.

The commissioner shall assist children in choosing a managed care organization to receive services under a children's health program, by:

(1) establishing a Web site to provide information about managed care organizations and to allow online enrollment;

(2) making applications and information on managed care organizations available to applicants and enrollees according to Title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Department of Health and Human Services; and

(3) making benefit educators available to assist applicants in choosing a managed care organization.

256L.28 FEDERAL APPROVAL.

The commissioner shall seek all federal waivers and approvals necessary to implement sections 256L.22 to 256L.28, including, but not limited to, waivers and approvals necessary to:

(1) coordinate medical assistance and MinnesotaCare coverage for children; and

(2) maximize receipt of the federal medical assistance match for covered children, by increasing income standards through the use of more liberal income methodologies as provided under United States Code, title 42, sections 1396a and 1396u-1.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subp. 5. **Earned income of wage and salary employees.** Earned income means earned income from employment before mandatory and voluntary payroll deductions. Earned income includes, but is not limited to, salaries, wages, tips, gratuities, commissions, incentive payments from work or training programs, payments made by an employer for regularly accrued vacation or sick leave, payment for jury duty, and profits from other activity earned by an individual's effort or labor. Earned income includes uniform, mileage, and meal allowances if federal income tax is deducted from the allowance. Earned income includes flexible work benefits received from an employer if the employee has the option of receiving the benefit or benefits in cash. Earned income received by persons employed on a contractual basis must be prorated over the period covered by the contract even when payments are received over a lesser period of time. When housing is provided as part of the total work compensation, the fair market value of such housing shall be considered as if it were paid in cash.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subp. 6. **Excluded income.** The administering agency shall exclude items A to H from annual income:

A. scholarships, work-study income, and grants that cover costs or reimburse for tuition, fees, books, and educational supplies;

B. student loans for tuition, fees, books, supplies, and living expenses;

C. state and federal earned income tax credits, in-kind noncash public assistance income such as food stamps or food support, energy assistance, foster care assistance, child care assistance, medical assistance, and housing subsidies;

D. earned income of full-time or part-time students up to the age of 19 who have not earned a high school diploma or GED high school equivalency diploma, including earnings from summer employment;

E. grant awards under the family subsidy program;

F. nonrecurring lump sum income that is earmarked and used for the purpose for which it is paid;

G. supplemental security income; and

H. income assigned to the public authority under Minnesota Statutes, section 256.741.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subp. 12. **Determination of unearned income.** Unearned income includes, but is not limited to, the cash portion of MFIP or DWP; adoption assistance; relative custody assistance received under Minnesota Statutes, section 257.85; interest; dividends; unemployment compensation; disability insurance payments; veteran benefits; pension payments; child support and spousal support received or anticipated to be received by a family including child support and maintenance distributed to the family under Minnesota Statutes, section 256.741, subdivision 15; insurance payments or settlements; retirement; survivor's and disability insurance (RSDI) payment; and severance payments. Expenditures necessary to secure payment of unearned income are deducted from unearned income. Payments for illness or disability, except for those payments described as earned income in subpart 5, are considered unearned income whether the premium payments are made wholly or in part by an employer or by a recipient.

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Subp. 13. **Treatment of lump-sum payments.** Lump-sum payments received by a family must be considered earned income under subparts 7 to 11 or unearned income according to subpart 12. Nonrecurring lump sums that are earmarked and used for the purpose for which they are paid are not to be included in the determination of income. All other lump sums are to be annualized over 12 months. The sale of property including, but not limited to, a residence is not considered income up to the amount of the original purchase price plus improvements.