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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 3467

03/23/2016 Authored by Dean, M.; Ecklund; Albright; Moran; Murphy, E., and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
03/31/2016 Adoption of Report: Re-referred to the Committee on Health and Human Services Finance
04/18/2016 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

1.1 relating to state government; making supplemental appropriations for human
1.2 services, health, and related boards; modifying provisions governing continuing
1.3 care, health care, MNsure, Department of Health programs, chemical and
1.4 mental health services, children and family services, health licensing boards,
1.5 and miscellaneous health and human services programs; making technical
1.6 changes; adjusting rates for nursing facilities in border cities; dental payment
1.7 rate, and child care assistance for cities located in multiple counties; creating
1.8 licenses relating to orthotics, genetic counselors, and massage and body therapy;
1.9 requiring reports; modifying fees; appropriating money; amending Minnesota
1.10 Statutes 2014, sections 13.3805, by adding a subdivision; 62J.495, subdivision 4;
1.11 62J.496, subdivision 1; 62V.04, subdivisions 2, 3, 4; 62V.05, subdivision 2, by
1.12 adding a subdivision; 62V.11, by adding a subdivision; 119B.13, subdivision 1;
1.13 144.05, by adding a subdivision; 144.293, subdivision 2; 144A.071, subdivisions
1.14 4c, 4d; 144A.073, subdivisions 13, 14, by adding a subdivision; 144A.471,
1.15 subdivision 9; 144A.611, subdivisions 1, 2, by adding a subdivision; 144A.75,
1.16 subdivisions 5, 6, 8, by adding a subdivision; 145.4716, subdivision 2, by adding
1.17 a subdivision; 146A.06, subdivision 3; 146A.09, by adding a subdivision;
1.18 149A.50, subdivision 2; 157.15, subdivision 14; 245.99, subdivision 2; 254B.03,
1.19 subdivision 4; 254B.04, subdivision 2a; 254B.06, subdivision 2, by adding a
1.20 subdivision; 256.01, by adding a subdivision; 256B.042, by adding a subdivision;
1.21 256B.0621, subdivision 10; 256B.0625, by adding subdivisions; 256B.0644;
1.22 256B.0924, by adding a subdivision; 256B.15, subdivisions 1a, 2, by adding
1.23 a subdivision; 256D.051, subdivision 6b; 256L.02, by adding a subdivision;
1.24 327.14, subdivision 9; 518.175, subdivision 5; 518A.34; 518A.36; 609.3241;
1.25 626.558, subdivisions 1, 2, by adding a subdivision; Minnesota Statutes 2015
1.26 Supplement, sections 62V.03, subdivision 2; 144.4961, subdivisions 3, 4, 5, 6,
1.27 8, by adding a subdivision; 144A.75, subdivision 13; 145.4131, subdivision 1;
1.28 149A.92, subdivision 1; 245.735, subdivisions 3, 4; 256B.059, subdivision 5;
1.29 256B.0625, subdivisions 17a, 18a, 20, 64; 256B.431, subdivision 36; 256B.441,
1.30 subdivisions 13, 53, 66; 256B.76, subdivision 2; 256B.766; 518A.26, subdivision
1.31 14; 518A.39, subdivision 2; Laws 2015, chapter 71, article 8, section 24;
1.32 article 14, sections 2, subdivision 5, as amended; 4, subdivisions 1, 3, 5, 10,
1.33 11; 9; proposing coding for new law in Minnesota Statutes, chapters 45; 62V;
1.34 144; 145; 148; 245A; 254B; 256B; 325F; 518A; proposing coding for new
1.35 law as Minnesota Statutes, chapters 147F; 153B; repealing Minnesota Statutes
1.36 2014, sections 62V.01; 62V.02; 62V.03, subdivisions 1, 3; 62V.04; 62V.05,
1.37 subdivisions 1, 2, 3, 4, 5, 9, 10; 62V.06; 62V.07; 62V.08; 62V.09; 62V.10; 62V.11,
1.38 subdivisions 1, 2, 4; 144.058; 149A.92, subdivision 11; 179A.50; 179A.51;
1.39

2.1 179A.52; 179A.53; Minnesota Statutes 2015 Supplement, sections 62V.03,
 2.2 subdivision 2; 62V.05, subdivisions 6, 7, 8, 11; 62V.051; Minnesota Rules,
 2.3 parts 7700.0010; 7700.0020; 7700.0030; 7700.0040; 7700.0050; 7700.0060;
 2.4 7700.0070; 7700.0080; 7700.0090; 7700.0100; 7700.0101; 7700.0105.

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

2.6 **ARTICLE 1**

2.7 **CONTINUING CARE**

2.8 Section 1. **[62V.055] ADDITIONAL NOTICE TO APPLICANTS.**

2.9 The board, in consultation with the commissioner of human services, shall include in
 2.10 the combined application for medical assistance, MinnesotaCare, and qualified health plan
 2.11 coverage available through the MNsure portal, information and notice on the following:

2.12 (1) that when an applicant submits the combined application, eligibility for
 2.13 subsidized coverage will be determined in the following order:

2.14 (i) medical assistance;

2.15 (ii) MinnesotaCare;

2.16 (iii) advanced premium tax credits and cost-sharing subsidies; and

2.17 (iv) qualified health plan coverage without a subsidy;

2.18 (2) persons eligible for medical assistance are not eligible for MinnesotaCare, and
 2.19 persons eligible for medical assistance or MinnesotaCare are not eligible for advanced
 2.20 premium tax credits and cost-sharing subsidies; and

2.21 (3) if a person enrolls in medical assistance, the state may claim repayment for the
 2.22 cost of medical care or premiums paid for that care from the person's estate.

2.23 Sec. 2. Minnesota Statutes 2014, section 144A.071, subdivision 4c, is amended to read:

2.24 Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The
 2.25 commissioner of health, in coordination with the commissioner of human services, may
 2.26 approve the renovation, replacement, upgrading, or relocation of a nursing home or
 2.27 boarding care home, under the following conditions:

2.28 (1) to license and certify an 80-bed city-owned facility in Nicollet County to be
 2.29 constructed on the site of a new city-owned hospital to replace an existing 85-bed facility
 2.30 attached to a hospital that is also being replaced. The threshold allowed for this project
 2.31 under section 144A.073 shall be the maximum amount available to pay the additional
 2.32 medical assistance costs of the new facility;

2.33 (2) to license and certify 29 beds to be added to an existing 69-bed facility in St.
 2.34 Louis County, provided that the 29 beds must be transferred from active or layaway status
 2.35 at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

3.1 The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment
3.2 rate at that facility shall not be adjusted as a result of this transfer. The operating payment
3.3 rate of the facility adding beds after completion of this project shall be the same as it was
3.4 on the day prior to the day the beds are licensed and certified. This project shall not
3.5 proceed unless it is approved and financed under the provisions of section 144A.073;

3.6 (3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of
3.7 the new beds are transferred from a 45-bed facility in Austin under common ownership
3.8 that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea
3.9 under common ownership; (ii) the commissioner of human services is authorized by the
3.10 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii)
3.11 money is available from planned closures of facilities under common ownership to make
3.12 implementation of this clause budget-neutral to the state. The bed capacity of the Albert
3.13 Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the
3.14 new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's
3.15 disease or related dementias;

3.16 (4) to license and certify up to 80 beds transferred from an existing state-owned
3.17 nursing facility in Cass County to a new facility located on the grounds of the
3.18 Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be
3.19 determined based on the interim and settle-up payment provisions of Minnesota Rules,
3.20 part 9549.0057, and the reimbursement provisions of section 256B.431. The property
3.21 payment rate for the first three years of operation shall be \$35 per day. For subsequent
3.22 years, the property payment rate of \$35 per day shall be adjusted for inflation as provided
3.23 in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract
3.24 under section 256B.434;

3.25 (5) to initiate a pilot program to license and certify up to 80 beds transferred from
3.26 an existing county-owned nursing facility in Steele County relocated to the site of a new
3.27 acute care facility as part of the county's Communities for a Lifetime comprehensive plan
3.28 to create innovative responses to the aging of its population. Upon relocation to the new
3.29 site, the nursing facility shall delicense 28 beds. The ~~property~~ payment rate for the first
3.30 ~~three years of operation of~~ external fixed costs for the new facility shall be increased by an
3.31 amount as calculated according to items (i) to (v):

3.32 (i) compute the estimated decrease in medical assistance residents served by the
3.33 nursing facility by multiplying the decrease in licensed beds by the historical percentage
3.34 of medical assistance resident days;

3.35 (ii) compute the annual savings to the medical assistance program from the
3.36 delicensure of 28 beds by multiplying the anticipated decrease in medical assistance

4.1 residents, determined in item (i), by the existing facility's weighted average payment rate
4.2 multiplied by 365;

4.3 (iii) compute the anticipated annual costs for community-based services by
4.4 multiplying the anticipated decrease in medical assistance residents served by the nursing
4.5 facility, determined in item (i), by the average monthly elderly waiver service costs for
4.6 individuals in Steele County multiplied by 12;

4.7 (iv) subtract the amount in item (iii) from the amount in item (ii); and

4.8 (v) divide the amount in item (iv) by an amount equal to the relocated nursing
4.9 facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c),
4.10 multiplied by the historical percentage of medical assistance resident days; and

4.11 ~~For subsequent years, the adjusted property payment rate shall be adjusted for~~
4.12 ~~inflation as provided in section 256B.434, subdivision 4, paragraph (e), as long as the~~
4.13 ~~facility has a contract under section 256B.434; and~~

4.14 (6) to consolidate and relocate nursing facility beds to a new site in Goodhue County
4.15 and to integrate these services with other community-based programs and services under a
4.16 communities for a lifetime pilot program and comprehensive plan to create innovative
4.17 responses to the aging of its population. ~~Eighty beds in the city of Red Wing shall be~~
4.18 ~~transferred from the downsizing and relocation of an existing 84-bed, hospital-owned~~
4.19 ~~nursing facility and the entire closure or downsizing of beds from a 65-bed nonprofit~~
4.20 ~~nursing facility in the community resulting in the delicensure of 69 beds in the two~~
4.21 ~~existing facilities~~ Two nursing facilities, one for 84 beds and one for 65 beds, in the city of
4.22 Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed
4.23 nursing facility resulting in the delicensure of 85 beds. Notwithstanding the carryforward
4.24 of the approval authority in section 144A.073, subdivision 11, the funding approved in
4.25 April 2009 by the commissioner of health for a project in Goodhue County shall not carry
4.26 forward. The closure of the ~~69~~ 85 beds shall not be eligible for a planned closure rate
4.27 adjustment under section 256B.437. The construction project permitted in this clause shall
4.28 not be eligible for a threshold project rate adjustment under section 256B.434, subdivision
4.29 4f. ~~The property payment rate for the first three years of operation of~~ external fixed costs for
4.30 the new facility shall be increased by an amount as calculated according to items (i) to (vi):
4.31 (i) compute the estimated decrease in medical assistance residents served by both
4.32 nursing facilities by multiplying the difference between the occupied beds of the two
4.33 nursing facilities for the reporting year ending September 30, 2009, and the projected
4.34 occupancy of the facility at 95 percent occupancy by the historical percentage of medical
4.35 assistance resident days;

5.1 (ii) compute the annual savings to the medical assistance program from the
5.2 delicensure by multiplying the anticipated decrease in the medical assistance residents,
5.3 determined in item (i), by the hospital-owned nursing facility weighted average payment
5.4 rate multiplied by 365;

5.5 (iii) compute the anticipated annual costs for community-based services by
5.6 multiplying the anticipated decrease in medical assistance residents served by the
5.7 facilities, determined in item (i), by the average monthly elderly waiver service costs for
5.8 individuals in Goodhue County multiplied by 12;

5.9 (iv) subtract the amount in item (iii) from the amount in item (ii);

5.10 (v) multiply the amount in item (iv) by ~~48.5~~ 57.2 percent; and

5.11 (vi) divide the difference of the amount in item (iv) and the amount in item (v) by an
5.12 amount equal to the relocated nursing facility's occupancy factor under section 256B.431,
5.13 subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance
5.14 resident days.

5.15 ~~For subsequent years, the adjusted property payment rate shall be adjusted for~~
5.16 ~~inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the~~
5.17 ~~facility has a contract under section 256B.434.~~

5.18 (b) Projects approved under this subdivision shall be treated in a manner equivalent
5.19 to projects approved under subdivision 4a.

5.20 **EFFECTIVE DATE.** This section is effective for rate years beginning on or after
5.21 January 1, 2017, except that the amendment to paragraph (a), clause (6), transferring the
5.22 rate adjustment in items (i) to (vi) from the property payment rate to the payment rate for
5.23 external fixed costs, is effective for rate years beginning on or after January 1, 2017, or
5.24 upon completion of the closure and new construction authorized in paragraph (a), clause
5.25 (6), whichever is later. The commissioner of human services shall notify the revisor
5.26 of statutes when the section is effective.

5.27 Sec. 3. Minnesota Statutes 2014, section 144A.071, subdivision 4d, is amended to read:

5.28 Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health,
5.29 in consultation with the commissioner of human services, may approve a request for
5.30 consolidation of nursing facilities which includes the closure of one or more facilities
5.31 and the upgrading of the physical plant of the remaining nursing facility or facilities,
5.32 the costs of which exceed the threshold project limit under subdivision 2, clause (a).
5.33 The commissioners shall consider the criteria in this section, section 144A.073, and
5.34 section 256B.437, in approving or rejecting a consolidation proposal. In the event the

6.1 commissioners approve the request, the commissioner of human services shall calculate a
6.2 ~~property~~ an external fixed costs rate adjustment according to clauses (1) to (3):

6.3 (1) the closure of beds shall not be eligible for a planned closure rate adjustment
6.4 under section 256B.437, subdivision 6;

6.5 (2) the construction project permitted in this clause shall not be eligible for a
6.6 threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium
6.7 exception adjustment under section 144A.073; and

6.8 (3) the ~~property~~ payment rate for external fixed costs for a remaining facility or
6.9 facilities shall be increased by an amount equal to 65 percent of the projected net cost
6.10 savings to the state calculated in paragraph (b), divided by the state's medical assistance
6.11 percentage of medical assistance dollars, and then divided by estimated medical assistance
6.12 resident days, as determined in paragraph (c), of the remaining nursing facility or facilities
6.13 in the request in this paragraph. The rate adjustment is effective on the later of the first
6.14 day of the month following completion of the construction upgrades in the consolidation
6.15 plan or the first day of the month following the complete closure of a facility designated
6.16 for closure in the consolidation plan. If more than one facility is receiving upgrades in
6.17 the consolidation plan, each facility's date of construction completion must be evaluated
6.18 separately.

6.19 (b) For purposes of calculating the net cost savings to the state, the commissioner
6.20 shall consider clauses (1) to (7):

6.21 (1) the annual savings from estimated medical assistance payments from the net
6.22 number of beds closed taking into consideration only beds that are in active service on the
6.23 date of the request and that have been in active service for at least three years;

6.24 (2) the estimated annual cost of increased case load of individuals receiving services
6.25 under the elderly waiver;

6.26 (3) the estimated annual cost of elderly waiver recipients receiving support under
6.27 group residential housing;

6.28 (4) the estimated annual cost of increased case load of individuals receiving services
6.29 under the alternative care program;

6.30 (5) the annual loss of license surcharge payments on closed beds;

6.31 (6) the savings from not paying planned closure rate adjustments that the facilities
6.32 would otherwise be eligible for under section 256B.437; and

6.33 (7) the savings from not paying ~~property~~ external fixed costs payment rate
6.34 adjustments from submission of renovation costs that would otherwise be eligible as
6.35 threshold projects under section 256B.434, subdivision 4f.

7.1 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
 7.2 assistance resident days of the remaining facility or facilities shall be computed assuming
 7.3 95 percent occupancy multiplied by the historical percentage of medical assistance
 7.4 resident days of the remaining facility or facilities, as reported on the facility's or facilities'
 7.5 most recent nursing facility statistical and cost report filed before the plan of closure
 7.6 is submitted, multiplied by 365.

7.7 (d) For purposes of net cost of savings to the state in paragraph (b), the average
 7.8 occupancy percentages will be those reported on the facility's or facilities' most recent
 7.9 nursing facility statistical and cost report filed before the plan of closure is submitted, and
 7.10 the average payment rates shall be calculated based on the approved payment rates in
 7.11 effect at the time the consolidation request is submitted.

7.12 (e) To qualify for the ~~property~~ external fixed costs payment rate adjustment under
 7.13 this ~~provision~~ subdivision, the closing facilities shall:

7.14 (1) submit an application for closure according to section 256B.437, subdivision
 7.15 3; and

7.16 (2) follow the resident relocation provisions of section 144A.161.

7.17 (f) The county or counties in which a facility or facilities are closed under this
 7.18 subdivision shall not be eligible for designation as a hardship area under section 144A.071,
 7.19 subdivision 3, for five years from the date of the approval of the proposed consolidation.
 7.20 The applicant shall notify the county of this limitation and the county shall acknowledge
 7.21 this in a letter of support.

7.22 **EFFECTIVE DATE.** This section is effective for rate years beginning on or after
 7.23 January 1, 2017.

7.24 Sec. 4. Minnesota Statutes 2014, section 144A.073, subdivision 13, is amended to read:

7.25 Subd. 13. **Moratorium exception funding.** In fiscal year 2013, the commissioner
 7.26 of health may approve moratorium exception projects under this section for which the
 7.27 full annualized state share of medical assistance costs does not exceed \$1,000,000 plus
 7.28 any carryover of previous appropriations for this purpose.

7.29 Sec. 5. Minnesota Statutes 2014, section 144A.073, subdivision 14, is amended to read:

7.30 Subd. 14. **Moratorium exception funding.** In fiscal year 2015, the commissioner
 7.31 of health may approve moratorium exception projects under this section for which the
 7.32 full annualized state share of medical assistance costs does not exceed \$1,000,000 plus
 7.33 any carryover of previous appropriations for this purpose.

8.1 Sec. 6. Minnesota Statutes 2014, section 144A.073, is amended by adding a
8.2 subdivision to read:

8.3 Subd. 15. **Moratorium exception funding.** In fiscal year 2017, the commissioner
8.4 may approve moratorium exception projects under this section for which the full
8.5 annualized state share of medical assistance costs does not exceed \$1,000,000 plus any
8.6 carryover of previous appropriations for this purpose.

8.7 Sec. 7. Minnesota Statutes 2014, section 144A.611, subdivision 1, is amended to read:

8.8 Subdivision 1. **Nursing homes and certified boarding care homes.** The actual
8.9 costs of tuition and textbooks and reasonable expenses for the competency evaluation
8.10 or the nursing assistant training program and competency evaluation approved under
8.11 section 144A.61, which are paid to nursing assistants or adult training programs pursuant
8.12 to ~~subdivision~~ subdivisions 2 and 4, are a reimbursable expense for nursing homes
8.13 and certified boarding care homes under ~~the provisions of chapter 256B and the rules~~
8.14 ~~promulgated thereunder~~ section 256B.431, subdivision 36.

8.15 Sec. 8. Minnesota Statutes 2014, section 144A.611, subdivision 2, is amended to read:

8.16 Subd. 2. **Nursing assistants Reimbursement for training program and**
8.17 **competency evaluation costs.** A nursing assistant who has completed an approved
8.18 competency evaluation or an approved training program and competency evaluation
8.19 shall be reimbursed by the nursing home or certified boarding care home for actual costs
8.20 of tuition and textbooks and reasonable expenses for the competency evaluation or the
8.21 training program and competency evaluation 90 days after the date of employment, or
8.22 upon completion of the approved training program, whichever is later.

8.23 Sec. 9. Minnesota Statutes 2014, section 144A.611, is amended by adding a
8.24 subdivision to read:

8.25 Subd. 4. **Reimbursement for adult basic education components.** (a) Nursing
8.26 facilities and certified boarding care homes shall provide reimbursement for costs related
8.27 to additional adult basic education components of an approved nursing assistant training
8.28 program, to:

8.29 (1) an adult training program that provided an approved nursing assistant training
8.30 program to an employee of the nursing facility or boarding care home; or

8.31 (2) a nursing assistant who is an employee of the nursing facility or boarding care
8.32 home and completed an approved nursing assistant training program provided by an
8.33 adult training program.

9.1 (b) For purposes of this subdivision, adult basic education components of a nursing
9.2 assistant training program must include the following, if needed: training in mathematics,
9.3 vocabulary, literacy skills, workplace skills, resume writing, and job interview skills.
9.4 Reimbursement provided under this subdivision shall not exceed 30 percent of the cost of
9.5 tuition, textbooks, and competency evaluation.

9.6 (c) An adult training program is prohibited from billing program students, nursing
9.7 facilities, or certified boarding care homes for costs under this subdivision until the
9.8 program student has been employed by the nursing facility as a certified nursing assistant
9.9 for at least 90 days.

9.10 **EFFECTIVE DATE.** This section is effective for costs incurred on or after October
9.11 1, 2016.

9.12 Sec. 10. Minnesota Statutes 2014, section 256B.042, is amended by adding a
9.13 subdivision to read:

9.14 Subd. 1a. **Additional notice to applicants.** An application for medical assistance
9.15 must include a statement, prominently displayed, that if any person on the application
9.16 enrolls in medical assistance, the state may claim repayment for the cost of medical care
9.17 or premiums paid for care from that person's estate.

9.18 Sec. 11. Minnesota Statutes 2015 Supplement, section 256B.059, subdivision 5,
9.19 is amended to read:

9.20 Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for
9.21 medical assistance benefits following the first continuous period of institutionalization on
9.22 or after October 1, 1989, assets considered available to the institutionalized spouse shall
9.23 be the total value of all assets in which either spouse has an ownership interest, reduced by
9.24 the following amount for the community spouse:

9.25 (1) prior to July 1, 1994, the greater of:

9.26 (i) \$14,148;

9.27 (ii) the lesser of the spousal share or \$70,740; or

9.28 (iii) the amount required by court order to be paid to the community spouse;

9.29 (2) for persons whose date of initial determination of eligibility for medical

9.30 assistance following their first continuous period of institutionalization occurs on or after

9.31 July 1, 1994, the greater of:

9.32 (i) \$20,000;

9.33 (ii) the lesser of the spousal share or \$70,740; or

9.34 (iii) the amount required by court order to be paid to the community spouse.

10.1 The value of assets transferred for the sole benefit of the community spouse under section
10.2 256B.0595, subdivision 4, in combination with other assets available to the community
10.3 spouse under this section, cannot exceed the limit for the community spouse asset
10.4 allowance determined under subdivision 3 or 4. Assets that exceed this allowance shall
10.5 be considered available to the institutionalized spouse. If the community spouse asset
10.6 allowance has been increased under subdivision 4, then the assets considered available to
10.7 the institutionalized spouse under this subdivision shall be further reduced by the value of
10.8 additional amounts allowed under subdivision 4.

10.9 (b) An institutionalized spouse may be found eligible for medical assistance even
10.10 though assets in excess of the allowable amount are found to be available under paragraph
10.11 (a) if the assets are owned jointly or individually by the community spouse, and the
10.12 institutionalized spouse cannot use those assets to pay for the cost of care without the
10.13 consent of the community spouse, and if:

10.14 (i) the institutionalized spouse assigns to the commissioner the right to support from
10.15 the community spouse under section 256B.14, subdivision 3;

10.16 (ii) the institutionalized spouse lacks the ability to execute an assignment due to a
10.17 physical or mental impairment; ~~or~~

10.18 (iii) the denial of eligibility would cause an imminent threat to the institutionalized
10.19 spouse's health and well-being; or

10.20 (iv) the assets in excess of the amount under paragraph (a) are assets owned by the
10.21 community spouse, and the denial of eligibility would cause an undue hardship to the
10.22 family due to the loss of retirement funds for the community spouse or funds protected for
10.23 the postsecondary education of a child under age 25. For purposes of this clause, only
10.24 retirement assets held by the community spouse in a tax-deferred retirement account,
10.25 including a defined benefit plan, defined contribution plan, an employer-sponsored
10.26 individual retirement arrangement, or individually purchased individual retirement
10.27 arrangement are protected, and are only protected until the community spouse is eligible to
10.28 withdraw retirement funds from any or all accounts without penalty. For purposes of this
10.29 clause, only funds in a plan designated under section 529 of the Internal Revenue Code
10.30 on behalf of a child of either or both spouses who is under the age of 25 are protected.
10.31 There shall not be an assignment of spousal support to the commissioner or a cause of
10.32 action against the individual's spouse under section 256B.14, subdivision 3, for the funds
10.33 in the protected retirement and college savings accounts.

10.34 (c) After the month in which the institutionalized spouse is determined eligible for
10.35 medical assistance, during the continuous period of institutionalization, no assets of the

11.1 community spouse are considered available to the institutionalized spouse, unless the
11.2 institutionalized spouse has been found eligible under paragraph (b).

11.3 (d) Assets determined to be available to the institutionalized spouse under this
11.4 section must be used for the health care or personal needs of the institutionalized spouse.

11.5 (e) For purposes of this section, assets do not include assets excluded under the
11.6 Supplemental Security Income program.

11.7 **EFFECTIVE DATE.** This section is effective June 1, 2016.

11.8 Sec. 12. Minnesota Statutes 2014, section 256B.15, subdivision 1a, is amended to read:

11.9 Subd. 1a. **Estates subject to claims.** (a) If a person receives any medical assistance
11.10 hereunder, on the person's death, if single, or on the death of the survivor of a married
11.11 couple, either or both of whom received medical assistance, or as otherwise provided
11.12 for in this section, the total amount paid for medical assistance rendered for the person
11.13 and spouse shall be filed as a claim against the estate of the person or the estate of the
11.14 surviving spouse in the court having jurisdiction to probate the estate or to issue a decree
11.15 of descent according to sections 525.31 to 525.313.

11.16 (b) For the purposes of this section, the person's estate must consist of:

11.17 (1) the person's probate estate;

11.18 (2) all of the person's interests or proceeds of those interests in real property the
11.19 person owned as a life tenant or as a joint tenant with a right of survivorship at the time of
11.20 the person's death;

11.21 (3) all of the person's interests or proceeds of those interests in securities the person
11.22 owned in beneficiary form as provided under sections 524.6-301 to 524.6-311 at the time
11.23 of the person's death, to the extent the interests or proceeds of those interests become part
11.24 of the probate estate under section 524.6-307;

11.25 (4) all of the person's interests in joint accounts, multiple-party accounts, and
11.26 pay-on-death accounts, brokerage accounts, investment accounts, or the proceeds of
11.27 those accounts, as provided under sections 524.6-201 to 524.6-214 at the time of the
11.28 person's death to the extent the interests become part of the probate estate under section
11.29 524.6-207; and

11.30 (5) assets conveyed to a survivor, heir, or assign of the person through survivorship,
11.31 living trust, or other arrangements.

11.32 (c) For the purpose of this section and recovery in a surviving spouse's estate for
11.33 medical assistance paid for a predeceased spouse, the estate must consist of all of the legal
11.34 title and interests the deceased individual's predeceased spouse had in jointly owned or
11.35 marital property at the time of the spouse's death, as defined in subdivision 2b, and the

12.1 proceeds of those interests, that passed to the deceased individual or another individual, a
12.2 survivor, an heir, or an assign of the predeceased spouse through a joint tenancy, tenancy
12.3 in common, survivorship, life estate, living trust, or other arrangement. A deceased
12.4 recipient who, at death, owned the property jointly with the surviving spouse shall have
12.5 an interest in the entire property.

12.6 (d) For the purpose of recovery in a single person's estate or the estate of a survivor
12.7 of a married couple, "other arrangement" includes any other means by which title to all or
12.8 any part of the jointly owned or marital property or interest passed from the predeceased
12.9 spouse to another including, but not limited to, transfers between spouses which are
12.10 permitted, prohibited, or penalized for purposes of medical assistance.

12.11 (e) A claim shall be filed if medical assistance was rendered for either or both
12.12 persons under one of the following circumstances:

12.13 (1) the person was over 55 years of age, and received services under this chapter
12.14 prior to January 1, 2014;

12.15 (2) the person resided in a medical institution for six months or longer, received
12.16 services under this chapter, and, at the time of institutionalization or application for
12.17 medical assistance, whichever is later, the person could not have reasonably been expected
12.18 to be discharged and returned home, as certified in writing by the person's treating
12.19 physician. For purposes of this section only, a "medical institution" means a skilled
12.20 nursing facility, intermediate care facility, intermediate care facility for persons with
12.21 developmental disabilities, nursing facility, or inpatient hospital; ~~or~~

12.22 (3) the person received general assistance medical care services under chapter
12.23 256D; ~~or~~

12.24 (4) the person was 55 years of age or older and received medical assistance
12.25 services on or after January 1, 2014, that consisted of nursing facility services, home and
12.26 community-based services, or related hospital and prescription drug benefits.

12.27 (f) The claim shall be considered an expense of the last illness of the decedent for
12.28 the purpose of section 524.3-805. Notwithstanding any law or rule to the contrary, a
12.29 state or county agency with a claim under this section must be a creditor under section
12.30 524.6-307. Any statute of limitations that purports to limit any county agency or the state
12.31 agency, or both, to recover for medical assistance granted hereunder shall not apply to any
12.32 claim made hereunder for reimbursement for any medical assistance granted hereunder.
12.33 Notice of the claim shall be given to all heirs and devisees of the decedent, and to other
12.34 persons with an ownership interest in the real property owned by the decedent at the time
12.35 of the decedent's death, whose identity can be ascertained with reasonable diligence. The
12.36 notice must include procedures and instructions for making an application for a hardship

13.1 waiver under subdivision 5; time frames for submitting an application and determination;
13.2 and information regarding appeal rights and procedures. Counties are entitled to one-half
13.3 of the nonfederal share of medical assistance collections from estates that are directly
13.4 attributable to county effort. Counties are entitled to ten percent of the collections for
13.5 alternative care directly attributable to county effort.

13.6 **EFFECTIVE DATE.** This section is effective upon federal approval and applies
13.7 retroactively to services rendered on or after January 1, 2014.

13.8 Sec. 13. Minnesota Statutes 2014, section 256B.15, is amended by adding a
13.9 subdivision to read:

13.10 **Subd. 11. Amending notices or liens arising out of notice.** (a) State agencies must
13.11 amend notices of potential claims and liens arising from the notices, if the notice was filed
13.12 after January 1, 2014, for medical assistance services rendered on or after January 1, 2014,
13.13 to a recipient who at the time services were rendered was 55 years of age or older and who
13.14 was not institutionalized as described in subdivision 1a, paragraph (e).

13.15 (b) The notices identified in paragraph (a) must be amended by removing the
13.16 amount of medical assistance rendered that did not consist of nursing facility services,
13.17 home and community-based services, as defined in subdivision 1a and related hospital
13.18 and prescription drug services.

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

13.20 Sec. 14. Minnesota Statutes 2014, section 256B.15, subdivision 2, is amended to read:

13.21 **Subd. 2. Limitations on claims.** (a) For services rendered prior to January 1, 2014,
13.22 the claim shall include only the total amount of medical assistance rendered after age 55 or
13.23 during a period of institutionalization described in subdivision 1a, paragraph (e), and the
13.24 total amount of general assistance medical care rendered, and shall not include interest.

13.25 (b) For services rendered on or after January 1, 2014, the claim shall include only:

13.26 (1) the amount of medical assistance rendered to recipients 55 years of age or older
13.27 and that consisted of nursing facility services, home and community-based services, and
13.28 related hospital and prescription drug services; and

13.29 (2) the total amount of medical assistance rendered during a period of
13.30 institutionalization described in subdivision 1a, paragraph (e).

13.31 The claim shall not include interest. For the purposes of this section, "home and
13.32 community-based services" has the same meaning it has when used in United States Code,
13.33 title 42, section 1396p, subsection (b), paragraph (1), subparagraph (B), clause (i).

14.1 (c) Claims that have been allowed but not paid shall bear interest according to
14.2 section 524.3-806, paragraph (d). A claim against the estate of a surviving spouse who did
14.3 not receive medical assistance, for medical assistance rendered for the predeceased spouse,
14.4 shall be payable from the full value of all of the predeceased spouse's assets and interests
14.5 which are part of the surviving spouse's estate under subdivisions 1a and 2b. Recovery of
14.6 medical assistance expenses in the nonrecipient surviving spouse's estate is limited to the
14.7 value of the assets of the estate that were marital property or jointly owned property at any
14.8 time during the marriage. The claim is not payable from the value of assets or proceeds of
14.9 assets in the estate attributable to a predeceased spouse whom the individual married after
14.10 the death of the predeceased recipient spouse for whom the claim is filed or from assets
14.11 and the proceeds of assets in the estate which the nonrecipient decedent spouse acquired
14.12 with assets which were not marital property or jointly owned property after the death of
14.13 the predeceased recipient spouse. Claims for alternative care shall be net of all premiums
14.14 paid under section 256B.0913, subdivision 12, on or after July 1, 2003, and shall be
14.15 limited to services provided on or after July 1, 2003. Claims against marital property shall
14.16 be limited to claims against recipients who died on or after July 1, 2009.

14.17 **EFFECTIVE DATE.** This section is effective upon federal approval and applies to
14.18 services rendered on or after January 1, 2014.

14.19 Sec. 15. Minnesota Statutes 2015 Supplement, section 256B.431, subdivision 36,
14.20 is amended to read:

14.21 Subd. 36. **Employee scholarship costs and training in English as a second**
14.22 **language.** (a) For the period between July 1, 2001, and June 30, 2003, the commissioner
14.23 shall provide to each nursing facility reimbursed under this section, section 256B.434,
14.24 or any other section, a scholarship per diem of 25 cents to the total operating payment
14.25 rate. For the 27-month period beginning October 1, 2015, through December 31, 2017,
14.26 the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing
14.27 facility with no scholarship per diem that is requesting a scholarship per diem to be added
14.28 to the external fixed payment rate to be used:

14.29 (1) for employee scholarships that satisfy the following requirements:

14.30 (i) scholarships are available to all employees who work an average of at least
14.31 ten hours per week at the facility except the administrator, and to reimburse student
14.32 loan expenses for newly hired and recently graduated registered nurses and licensed
14.33 practical nurses, and training expenses for nursing assistants as ~~defined~~ specified in section
14.34 144A.611, ~~subdivision~~ subdivisions 2 and 4, who are newly hired and have graduated
14.35 within the last 12 months; and

15.1 (ii) the course of study is expected to lead to career advancement with the facility or
15.2 in long-term care, including medical care interpreter services and social work; and

15.3 (2) to provide job-related training in English as a second language.

15.4 (b) All facilities may annually request a rate adjustment under this subdivision by
15.5 submitting information to the commissioner on a schedule and in a form supplied by the
15.6 commissioner. The commissioner shall allow a scholarship payment rate equal to the
15.7 reported and allowable costs divided by resident days.

15.8 (c) In calculating the per diem under paragraph (b), the commissioner shall allow
15.9 costs related to tuition, direct educational expenses, and reasonable costs as defined by the
15.10 commissioner for child care costs and transportation expenses related to direct educational
15.11 expenses.

15.12 (d) The rate increase under this subdivision is an optional rate add-on that the facility
15.13 must request from the commissioner in a manner prescribed by the commissioner. The
15.14 rate increase must be used for scholarships as specified in this subdivision.

15.15 (e) For instances in which a rate adjustment will be 15 cents or greater, nursing
15.16 facilities that close beds during a rate year may request to have their scholarship
15.17 adjustment under paragraph (b) recalculated by the commissioner for the remainder of the
15.18 rate year to reflect the reduction in resident days compared to the cost report year.

15.19 Sec. 16. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 13,
15.20 is amended to read:

15.21 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
15.22 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
15.23 section 144.122; family advisory council fee under section 144A.33; scholarships under
15.24 section 256B.431, subdivision 36; planned closure rate adjustments under section
15.25 256B.437; consolidation rate adjustments under section 144A.071, subdivisions 4c,
15.26 paragraph (a), clauses (5) and (6), and 4d; single bed room incentives under section
15.27 256B.431, subdivision 42; property taxes, assessments, and payments in lieu of taxes;
15.28 employer health insurance costs; quality improvement incentive payment rate adjustments
15.29 under subdivision 46c; performance-based incentive payments under subdivision 46d;
15.30 special dietary needs under subdivision 51b; and PERA.

15.31 Sec. 17. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 53,
15.32 is amended to read:

15.33 Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner
15.34 shall calculate a payment rate for external fixed costs.

16.1 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
16.2 shall be equal to \$8.86. For a facility licensed as both a nursing home and a boarding care
16.3 home, the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the
16.4 result of its number of nursing home beds divided by its total number of licensed beds.

16.5 (b) The portion related to the licensure fee under section 144.122, paragraph (d),
16.6 shall be the amount of the fee divided by actual resident days.

16.7 (c) The portion related to development and education of resident and family advisory
16.8 councils under section 144A.33 shall be \$5 divided by 365.

16.9 (d) The portion related to scholarships shall be determined under section 256B.431,
16.10 subdivision 36.

16.11 (e) The portion related to planned closure rate adjustments shall be as determined
16.12 under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436.

16.13 (f) The portion related to consolidation rate adjustments shall be as determined under
16.14 section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

16.15 ~~(f)~~ (g) The single bed room incentives shall be as determined under section
16.16 256B.431, subdivision 42.

16.17 ~~(g)~~ (h) The portions related to real estate taxes, special assessments, and payments
16.18 made in lieu of real estate taxes directly identified or allocated to the nursing facility shall
16.19 be the actual amounts divided by actual resident days.

16.20 ~~(h)~~ (i) The portion related to employer health insurance costs shall be the allowable
16.21 costs divided by resident days.

16.22 ~~(i)~~ (j) The portion related to the Public Employees Retirement Association shall
16.23 be actual costs divided by resident days.

16.24 ~~(j)~~ (k) The portion related to quality improvement incentive payment rate
16.25 adjustments shall be as determined under subdivision 46c.

16.26 ~~(k)~~ (l) The portion related to performance-based incentive payments shall be as
16.27 determined under subdivision 46d.

16.28 ~~(l)~~ (m) The portion related to special dietary needs shall be the per diem amount
16.29 determined under subdivision 51b.

16.30 ~~(m)~~ (n) The payment rate for external fixed costs shall be the sum of the amounts in
16.31 paragraphs (a) to ~~(l)~~ (m).

16.32 Sec. 18. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 66,
16.33 is amended to read:

16.34 Subd. 66. **Nursing facilities in border cities.** (a) Rate increases under this section
16.35 for a facility located in Breckenridge are effective for the rate year beginning January 1,

17.1 2016, and annually thereafter; Rate increases under this section for a facility located in
 17.2 Moorhead are effective for the rate year beginning January 1, 2020, and annually thereafter.

17.3 (b) Operating payment rates of a nonprofit nursing facility that exists on January
 17.4 1, 2015, is located anywhere within the boundaries of the city/cities of Breckenridge or
 17.5 Moorhead, and is reimbursed under this section, section 256B.431, or section 256B.434,
 17.6 shall be adjusted to be equal to the median RUG's rates, including comparable rate
 17.7 components as determined by the commissioner, for the equivalent RUG's weight of the
 17.8 nonprofit nursing facility or facilities located in an adjacent city in another state and in
 17.9 cities contiguous to the adjacent city. The commissioner must make the comparison
 17.10 required under this subdivision on October 1 of each year. The adjustment under this
 17.11 subdivision applies to the rates effective on the following January 1.

17.12 (c) The Minnesota facility's operating payment rate with a weight of 1.0 shall be
 17.13 computed by dividing the adjacent city's nursing facilities median operating payment rate
 17.14 with a weight of 1.02 by 1.02. ~~If the adjustments under this subdivision result in a rate that~~
 17.15 ~~exceeds the limits in subdivisions 50 and 51 in a given rate year, the facility's rate shall~~
 17.16 ~~not be subject to those limits for that rate year.~~ If a facility's rate is increased under this
 17.17 subdivision, the facility is not subject to the total care-related limit in subdivision 50 and is
 17.18 not limited to the other operating price established in subdivision 51. This subdivision
 17.19 shall apply only if it results in a higher operating payment rate than would otherwise be
 17.20 determined under this section, section 256B.431, or section 256B.434.

17.21 Sec. 19. **EMPLOYMENT SERVICES PILOT PROJECT; DAKOTA COUNTY.**

17.22 (a) Within available appropriations, the commissioner of human services shall
 17.23 request, by October 1, 2016, necessary federal authority from the Centers for Medicare
 17.24 and Medicaid Services to implement a community-based employment services pilot
 17.25 project in Dakota County. The pilot project must be available to people who are receiving
 17.26 services through home and community-based waivers authorized under Minnesota
 17.27 Statutes, sections 256B.092 and 256B.49, using a rate methodology consistent with the
 17.28 principles under Minnesota Statutes, section 256B.4914.

17.29 (b) Dakota County shall be:

17.30 (1) responsible for any portion of the state match of waiver expenses above the
 17.31 established disability waiver rates under Minnesota Statutes, section 256B.4914; and

17.32 (2) allocated resources for supportive employment services incurred by the use of
 17.33 employment exploration services, employment development services, and employment
 17.34 support services in Dakota County for Dakota County residents.

18.1 (c) The pilot project must provide the following employment services to people
18.2 receiving services through the home and community-based services waivers authorized
18.3 under Minnesota Statutes, sections 256B.092 and 256B.49:

18.4 (1) "employment exploration services" defined as community-based orientation
18.5 services that introduce a person to competitive employment opportunities in their
18.6 community through individualized educational activities, learning opportunities, work
18.7 experiences, and support services that result in the person making an informed decision
18.8 about working in competitively paying jobs in community businesses;

18.9 (2) "employment development services" defined as individualized services that
18.10 actively support a person to achieve paid employment in his or her community by assisting
18.11 the person with finding paid employment, becoming self-employed, or establishing
18.12 microenterprise businesses in the community; and

18.13 (3) "employment support services" defined as individualized services and supports
18.14 that assist people with maintaining competitive, integrated employment by providing a
18.15 broad range of training, coaching, and support strategies that not only assist individuals
18.16 and workgroups employed in paid job positions, but also support people working in
18.17 self-employment opportunities and microenterprise businesses with all aspects of effective
18.18 business operations. Employment support services must be provided in integrated
18.19 community settings.

18.20 (d) The commissioner of human services shall consult with Dakota County on
18.21 this pilot project and report the results of the project to the chairs and ranking minority
18.22 members of the legislative committees with jurisdiction over human services policy and
18.23 finance by January 15, 2019.

18.24 **EFFECTIVE DATE.** This section is effective July 1, 2016, or upon federal
18.25 approval, whichever is later, and expires on January 15, 2019. The commissioner of
18.26 human services shall notify the revisor of statutes when federal approval is obtained.

18.27 **Sec. 20. REVISOR'S INSTRUCTION.**

18.28 The revisor of statutes, in consultation with the Department of Human Services,
18.29 shall change the cross-references in Minnesota Rules, chapters 2960, 9503, and 9525,
18.30 resulting from the repealer adopted in rules found at 40 State Register 179. The revisor
18.31 may make technical and other necessary changes to sentence structure to preserve the
18.32 meaning of the text.

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

19.1 **ARTICLE 2**

19.2 **HEALTH CARE**

19.3 Section 1. **[256B.0562] IMPROVED OVERSIGHT OF MNSURE ELIGIBILITY**
 19.4 **DETERMINATIONS.**

19.5 Subdivision 1. **Implementation of OLA findings.** (a) The commissioner shall
 19.6 ensure that medical assistance and MinnesotaCare eligibility determinations through the
 19.7 MNsurre information technology system and through agency eligibility determination
 19.8 systems fully implement the recommendations made by the Office of the Legislative
 19.9 Auditor (OLA) in Report 14-22 – Oversight of MNsure Eligibility Determinations
 19.10 for Public Health Care Programs and Report 16-02 Oversight of MNsure Eligibility
 19.11 Determinations for Public Health Care Programs – Internal Controls and Compliance Audit.

19.12 (b) The commissioner may contract with a vendor to provide technical assistance to
 19.13 the commissioner in fully implementing the OLA report findings.

19.14 (c) The commissioner shall coordinate implementation of this section with the
 19.15 periodic data matching required under section 256B.0561.

19.16 (d) The commissioner shall implement this section using existing resources.

19.17 Subd. 2. **Duties of the commissioner.** (a) In fully implementing the OLA report
 19.18 recommendations, the commissioner shall:

19.19 (1) adequately verify that persons enrolled in public health care programs through
 19.20 MNsurre are eligible for those programs;

19.21 (2) provide adequate controls to ensure the accurate and complete transfer of
 19.22 recipient data from MNsure to the Department of Human Services' medical payment
 19.23 system, and to detect whether Office of MN.IT Services staff inappropriately access
 19.24 recipients' personal information;

19.25 (3) provide county human service eligibility workers with sufficient training on
 19.26 MNsurre;

19.27 (4) reverify that medical assistance and MinnesotaCare enrollees who enroll through
 19.28 MNsurre remain eligible for the program within the required time frames established
 19.29 in federal and state laws;

19.30 (5) establish an effective process to resolve discrepancies with Social Security
 19.31 numbers, citizenship or immigration status, or household income that MNsure identifies
 19.32 as needing further verification;

19.33 (6) eliminate payment of medical assistance and MinnesotaCare benefits for
 19.34 recipients whose income exceeds federal and state program limits;

19.35 (7) verify household size and member relationships when determining eligibility;

20.1 (8) ensure that applicants and recipients are enrolled in the correct public health
20.2 care program;

20.3 (9) eliminate payment of benefits for MinnesotaCare recipients who are also
20.4 enrolled in Medicare;

20.5 (10) verify that newborns turning age one remain eligible for medical assistance;

20.6 (11) correct MinnesotaCare billing errors, ensure that enrollees pay their premiums,
20.7 and terminate coverage for failure to pay premiums; and

20.8 (12) take all other steps necessary to fully implement the recommendations.

20.9 (b) The commissioner shall implement the OLA recommendations retroactively for
20.10 medical assistance and MinnesotaCare applications and renewals submitted on or after
20.11 January 1, 2016. The commissioner shall present quarterly reports to the OLA and the
20.12 chairs and ranking minority members of the legislative committees with jurisdiction
20.13 over health and human services policy and finance, beginning October 1, 2016, and
20.14 each quarter thereafter. The quarterly report submitted October 1, 2016, must include a
20.15 timetable for fully implementing the OLA recommendations. Each quarterly report must
20.16 include information on:

20.17 (1) progress in implementing the OLA recommendations;

20.18 (2) the number of medical assistance and MinnesotaCare applicants and enrollees
20.19 whose eligibility status was affected by implementation of the OLA recommendations,
20.20 reported quarterly, beginning with the January 1, 2016 through March 31, 2016 calendar
20.21 quarter; and

20.22 (3) savings to the state from implementing the OLA recommendations.

20.23 Subd. 3. **Office of Legislative Auditor.** The legislative auditor shall review each
20.24 quarterly report submitted by the commissioner of human services under subdivision 2
20.25 for accuracy and shall review compliance by the Department of Human Services with the
20.26 OLA report recommendations. The legislative auditor shall notify the chairs and ranking
20.27 minority members of the legislative committees with jurisdiction over health and human
20.28 services policy and finance on whether or not these requirements are met.

20.29 Subd. 4. **Special revenue account; use of savings.** (a) A medical assistance audit
20.30 special revenue account is established in the general fund. The commissioner shall deposit
20.31 into this account all savings achieved from implementing this section retroactively to
20.32 applications and renewals submitted on or after January 1, 2016, and all savings achieved
20.33 from implementation of periodic data matching under section 256B.0561 that are above
20.34 the forecasted savings for that initiative.

20.35 (b) Once the medical assistance audit special revenue account fund balance has
20.36 reached a sufficient level, the commissioner shall provide a onetime, five percent increase

21.1 in medical assistance payment rates for intermediate care facilities for persons with
21.2 developmental disabilities and the long-term care and community-based providers listed
21.3 in Laws 2014, chapter 312, article 27, section 75, paragraph (b). The increase shall be
21.4 limited to a 12-month period.

21.5 (c) Any further expenditures from the medical assistance audit special revenue
21.6 account are subject to legislative authorization.

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

21.8 Sec. 2. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 17a,
21.9 is amended to read:

21.10 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers
21.11 ambulance services. Providers shall bill ambulance services according to Medicare
21.12 criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective
21.13 for services rendered on or after July 1, 2001, medical assistance payments for ambulance
21.14 services shall be paid at the Medicare reimbursement rate or at the medical assistance
21.15 payment rate in effect on July 1, 2000, whichever is greater.

21.16 (b) Effective for services provided on or after July 1, 2016, medical assistance
21.17 payment rates for ambulance services identified in this paragraph are increased by five
21.18 percent. Capitation payments made to managed care plans and county-based purchasing
21.19 plans for ambulance services provided on or after January 1, 2017, shall be adjusted to
21.20 reflect this rate increase. The increased rate described in this paragraph applies to:

21.21 (1) an ambulance service provider whose base of operations, as defined in section
21.22 144E.10, is located outside the metropolitan counties listed in section 473.121, subdivision
21.23 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

21.24 (2) an ambulance service provider whose base of operations, as defined in section
21.25 144E.10, is located within a municipality with a population of less than 1,000.

21.26 Sec. 3. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
21.27 subdivision to read:

21.28 Subd. 60a. **Community emergency medical technician services.** (a) Medical
21.29 assistance covers services provided by a community emergency medical technician
21.30 (CEMT) who is certified under section 144E.275, subdivision 7, when the services are
21.31 provided in accordance with this subdivision.

21.32 (b) A CEMT may provide a posthospital discharge visit when ordered by a treating
21.33 physician. The posthospital discharge visit includes:

21.34 (1) verbal or visual reminders of discharge orders;

22.1 (2) recording and reporting of vital signs to the patient's primary care provider;

22.2 (3) medication access confirmation;

22.3 (4) food access confirmation; and

22.4 (5) identification of home hazards.

22.5 (c) Individuals who have repeat ambulance calls due to falls, have been discharged

22.6 from a nursing home, or have been identified by their primary care provider as at risk

22.7 for nursing home placement may receive a safety evaluation visit from a CEMT when

22.8 ordered by a primary care provider in accordance with the individual's care plan. A safety

22.9 evaluation visit includes:

22.10 (1) medication access confirmation;

22.11 (2) food access confirmation; and

22.12 (3) identification of home hazards.

22.13 (d) A CEMT shall be paid at \$9.75 per 15-minute increment. A safety evaluation visit

22.14 may not be billed for the same day as a posthospital discharge visit for the same recipient.

22.15 **EFFECTIVE DATE.** This section is effective January 1, 2017, or upon federal

22.16 approval, whichever is later.

22.17 Sec. 4. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 64,

22.18 is amended to read:

22.19 Subd. 64. **Investigational drugs, biological products, and devices.** Medical

22.20 assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do

22.21 not cover costs incidental to, associated with, or resulting from the use of investigational

22.22 drugs, biological products, or devices as defined in section 151.375, except that stiripentol

22.23 may be covered by the EPSDT program for eligible enrollees with a documented diagnosis

22.24 of Dravet syndrome, for whom all other available covered prescription medications for

22.25 Dravet syndrome have been exhausted. Stiripentol may only be covered if the treating

22.26 physician has received an individual patient investigational new drug (IND) for treatment

22.27 use from the United States Food and Drug Administration.

22.28 Sec. 5. Minnesota Statutes 2014, section 256B.0644, is amended to read:

22.29 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
22.30 **PROGRAMS.**

22.31 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a

22.32 health maintenance organization, as defined in chapter 62D, must participate as a provider

22.33 or contractor in the medical assistance program and MinnesotaCare as a condition of

23.1 participating as a provider in health insurance plans and programs or contractor for state
23.2 employees established under section 43A.18, the public employees insurance program
23.3 under section 43A.316, for health insurance plans offered to local statutory or home
23.4 rule charter city, county, and school district employees, the workers' compensation
23.5 system under section 176.135, and insurance plans provided through the Minnesota
23.6 Comprehensive Health Association under sections 62E.01 to 62E.19. The limitations
23.7 on insurance plans offered to local government employees shall not be applicable in
23.8 geographic areas where provider participation is limited by managed care contracts
23.9 with the Department of Human Services. This section does not apply to dental service
23.10 providers providing dental services outside the seven-county metropolitan area.

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

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

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

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

23.30 (c) Patients seen on a volunteer basis by the provider at a location other than
23.31 the provider's usual place of practice may be considered in meeting the participation
23.32 requirement in this section. The commissioner shall establish participation requirements
23.33 for health maintenance organizations. The commissioner shall provide lists of participating
23.34 medical assistance providers on a quarterly basis to the commissioner of management and
23.35 budget, the commissioner of labor and industry, and the commissioner of commerce. Each
23.36 of the commissioners shall develop and implement procedures to exclude as participating

24.1 providers in the program or programs under their jurisdiction those providers who do
24.2 not participate in the medical assistance program. The commissioner of management
24.3 and budget shall implement this section through contracts with participating health and
24.4 dental carriers.

24.5 (d) A volunteer dentist who has signed a volunteer agreement under section
24.6 256B.0625, subdivision 9a, shall not be considered to be participating in medical
24.7 assistance or MinnesotaCare for the purpose of this section.

24.8 Sec. 6. Minnesota Statutes 2015 Supplement, section 256B.76, subdivision 2, is
24.9 amended to read:

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

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

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

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

24.18 (c) Effective for services rendered on or after January 1, 2000, payment rates for
24.19 dental services shall be increased by three percent over the rates in effect on December
24.20 31, 1999.

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

24.24 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1,
24.25 2000, for managed care.

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

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

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

25.6 (i) Effective for services rendered on or after September 1, 2011, through June 30,
25.7 2013, payment rates for dental services shall be reduced by three percent. This reduction
25.8 does not apply to state-operated dental clinics in paragraph (f).

25.9 (j) Effective for services rendered on or after January 1, 2014, payment rates for
25.10 dental services shall be increased by five percent from the rates in effect on December
25.11 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f),
25.12 federally qualified health centers, rural health centers, and Indian health services. Effective
25.13 January 1, 2014, payments made to managed care plans and county-based purchasing
25.14 plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase
25.15 described in this paragraph.

25.16 (k) Effective for services rendered on or after July 1, 2015, through December
25.17 31, 2016, the commissioner shall increase payment rates for services furnished by
25.18 dental providers located outside of the seven-county metropolitan area by the maximum
25.19 percentage possible above the rates in effect on June 30, 2015, while remaining within
25.20 the limits of funding appropriated for this purpose. This increase does not apply to
25.21 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health
25.22 centers, and Indian health services. Effective January 1, 2016, through December 31,
25.23 2016, payments to managed care plans and county-based purchasing plans under sections
25.24 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph. The
25.25 commissioner shall require managed care and county-based purchasing plans to pass on
25.26 the full amount of the increase, in the form of higher payment rates to dental providers
25.27 located outside of the seven-county metropolitan area.

25.28 (l) Effective for services provided on or after January 1, 2017, the commissioner
25.29 shall increase payment rates by 9.65 percent above the rates in effect on June 30, 2015,
25.30 for dental services provided outside of the seven-county metropolitan area. This increase
25.31 does not apply to state-operated dental clinics in paragraph (f), federally qualified health
25.32 centers, rural health centers, or Indian health services. Effective January 1, 2017,
25.33 payments to managed care plans and county-based purchasing plans under sections
25.34 256B.69 and 256B.692 shall reflect the payment increase described in this paragraph.

26.1 Sec. 7. Minnesota Statutes 2015 Supplement, section 256B.766, is amended to read:

26.2 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

26.3 (a) Effective for services provided on or after July 1, 2009, total payments for basic
26.4 care services, shall be reduced by three percent, except that for the period July 1, 2009,
26.5 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
26.6 assistance and general assistance medical care programs, prior to third-party liability and
26.7 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
26.8 therapy services, occupational therapy services, and speech-language pathology and
26.9 related services as basic care services. The reduction in this paragraph shall apply to
26.10 physical therapy services, occupational therapy services, and speech-language pathology
26.11 and related services provided on or after July 1, 2010.

26.12 (b) Payments made to managed care plans and county-based purchasing plans shall
26.13 be reduced for services provided on or after October 1, 2009, to reflect the reduction
26.14 effective July 1, 2009, and payments made to the plans shall be reduced effective October
26.15 1, 2010, to reflect the reduction effective July 1, 2010.

26.16 (c) Effective for services provided on or after September 1, 2011, through June 30,
26.17 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
26.18 from the rates in effect on August 31, 2011.

26.19 (d) Effective for services provided on or after September 1, 2011, through June
26.20 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
26.21 and durable medical equipment not subject to a volume purchase contract, prosthetics
26.22 and orthotics, renal dialysis services, laboratory services, public health nursing services,
26.23 physical therapy services, occupational therapy services, speech therapy services,
26.24 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
26.25 purchase contract, and anesthesia services shall be reduced by three percent from the
26.26 rates in effect on August 31, 2011.

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

26.34 (f) Payments for medical supplies and durable medical equipment not subject to a
26.35 volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014,
26.36 through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies

27.1 and durable medical equipment not subject to a volume purchase contract, and prosthetics
27.2 and orthotics, provided on or after July 1, 2015, shall be increased by three percent from
27.3 the rates as determined under paragraph (i).

27.4 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
27.5 hospital facility fees, medical supplies and durable medical equipment not subject to a
27.6 volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital
27.7 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
27.8 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made
27.9 to managed care plans and county-based purchasing plans shall not be adjusted to reflect
27.10 payments under this paragraph.

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

27.15 (i) ~~Effective July 1, 2015, the medical assistance payment rate for durable medical~~
27.16 ~~equipment, prosthetics, orthotics, or supplies shall be restored to the January 1, 2008,~~
27.17 ~~medical assistance fee schedule, updated to include subsequent rate increases in the~~
27.18 ~~Medicare and medical assistance fee schedules, and including following categories of~~
27.19 ~~durable medical equipment shall be individually priced items for the following categories:~~
27.20 ~~enteral nutrition and supplies, customized and other specialized tracheostomy tubes and~~
27.21 ~~supplies, electric patient lifts, and durable medical equipment repair and service. This~~
27.22 ~~paragraph does not apply to medical supplies and durable medical equipment subject to~~
27.23 ~~a volume purchase contract, products subject to the preferred diabetic testing supply~~
27.24 ~~program, and items provided to dually eligible recipients when Medicare is the primary~~
27.25 ~~payer for the item. The commissioner shall not apply any medical assistance rate~~
27.26 ~~reductions to durable medical equipment as a result of Medicare competitive bidding.~~

27.27 (j) Effective July 1, 2015, medical assistance payment rates for durable medical
27.28 equipment, prosthetics, orthotics, or supplies shall be increased as follows:

27.29 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies
27.30 that were subject to the Medicare 2008 competitive bid shall be increased by 9.5 percent;
27.31 and

27.32 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies
27.33 on the medical assistance fee schedule, whether or not subject to the Medicare 2008
27.34 competitive bid, shall be increased by 2.94 percent, with this increase being applied after
27.35 calculation of any increased payment rate under clause (1).

28.1 This paragraph does not apply to medical supplies and durable medical equipment subject
28.2 to a volume purchase contract, products subject to the preferred diabetic testing supply
28.3 program, items provided to dually eligible recipients when Medicare is the primary payer
28.4 for the item, and individually priced items identified in paragraph (i). Payments made to
28.5 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
28.6 rate increases in this paragraph.

28.7 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2015.

28.8 **ARTICLE 3**

28.9 **MNSURE**

28.10 Section 1. **[45.0131] LEGISLATIVE ENACTMENT REQUIRED.**

28.11 Subdivision 1. **Agency agreements.** The commissioner of commerce shall not
28.12 enter into or renew any interagency agreement or service level agreement with a value of
28.13 more than \$100,000 a year, or related agreements with a cumulative value of more than
28.14 \$100,000 a year, with a state department, state agency, or the Office of MN.IT Services,
28.15 unless the specific agreement is authorized by enactment of a new law. If an agreement,
28.16 including an agreement in effect as of the effective date of this section, does not have a
28.17 specific expiration date, the agreement shall expire two years from the effective date of
28.18 this section or the effective date of the agreement, whichever is later, unless the specific
28.19 agreement is authorized by enactment of a new law.

28.20 Subd. 2. **Transfers.** Notwithstanding section 16A.285, the commissioner shall not
28.21 transfer appropriations and funds in amounts over \$100,000 across agency accounts or
28.22 programs, unless the specific transfer is authorized by enactment of a new law.

28.23 Subd. 3. **Definitions.** For purposes of this section, "state department" has the
28.24 meaning provided in section 15.01, and "state agency" has the meaning provided in
28.25 section 15.012.

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

28.27 Sec. 2. Minnesota Statutes 2015 Supplement, section 62V.03, subdivision 2, is
28.28 amended to read:

28.29 Subd. 2. **Application of other law.** (a) MNSure must be reviewed by the legislative
28.30 auditor under section 3.971. The legislative auditor shall audit the books, accounts, and
28.31 affairs of MNSure once each year or less frequently as the legislative auditor's funds and
28.32 personnel permit. Upon the audit of the financial accounts and affairs of MNSure, MNSure
28.33 is liable to the state for the total cost and expenses of the audit, including the salaries paid

29.1 to the examiners while actually engaged in making the examination. The legislative
29.2 auditor may bill MNsure either monthly or at the completion of the audit. All collections
29.3 received for the audits must be deposited in the general fund and are appropriated to
29.4 the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit
29.5 Commission is requested to direct the legislative auditor to report by March 1, 2014, to
29.6 the legislature on any duplication of services that occurs within state government as a
29.7 result of the creation of MNsure. The legislative auditor may make recommendations on
29.8 consolidating or eliminating any services deemed duplicative. The board shall reimburse
29.9 the legislative auditor for any costs incurred in the creation of this report.

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

29.12 (c) All meetings of the board and of the Minnesota Eligibility System Executive
29.13 Steering Committee established under section 62V.056 shall comply with the open
29.14 meeting law in chapter 13D.

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

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

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

29.22 Sec. 3. Minnesota Statutes 2014, section 62V.04, subdivision 2, is amended to read:

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

29.24 (1) three members appointed by the governor with the advice and consent of both the
29.25 senate and the house of representatives acting separately in accordance with paragraph (d),
29.26 with one member representing the interests of individual consumers eligible for individual
29.27 market coverage, one member representing individual consumers eligible for public health
29.28 care program coverage, and one member representing small employers. Members are
29.29 appointed to serve four-year terms following the initial staggered-term lot determination;

29.30 (2) three members appointed by the governor with the advice and consent of both the
29.31 senate and the house of representatives acting separately in accordance with paragraph (d)
29.32 who have demonstrated expertise, leadership, and innovation in the following areas: one
29.33 member representing the areas of health administration, health care finance, health plan
29.34 purchasing, and health care delivery systems; one member representing the areas of public
29.35 health, health disparities, public health care programs, and the uninsured; and one member

30.1 representing health policy issues related to the small group and individual markets.

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

30.4 ~~(3) the commissioner of human services or a designee~~ one member representing the
30.5 interests of the general public, appointed by the governor with the advice and consent of
30.6 both the senate and the house of representatives acting in accordance with paragraph (d).

30.7 A member appointed under this clause shall serve a four-year term.

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

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

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

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

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

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

30.22 Sec. 4. Minnesota Statutes 2014, section 62V.04, subdivision 3, is amended to read:

30.23 Subd. 3. **Terms.** (a) Board members may serve no more than two consecutive
30.24 terms, ~~except for the commissioner or the commissioner's designee, who shall serve~~
30.25 ~~until replaced by the governor.~~

30.26 (b) A board member may resign at any time by giving written notice to the board.

30.27 (c) The appointed members under subdivision 2, paragraph (a), clauses (1) and (2),
30.28 shall have an initial term of two, three, or four years, determined by lot by the secretary of
30.29 state.

30.30 Sec. 5. Minnesota Statutes 2014, section 62V.04, subdivision 4, is amended to read:

30.31 Subd. 4. **Conflicts of interest.** (a) Within one year prior to or at any time during
30.32 their appointed term, board members appointed under subdivision 2, paragraph (a),
30.33 ~~clauses (1) and (2),~~ shall not be employed by, be a member of the board of directors of, or
30.34 otherwise be a representative of a health carrier, institutional health care provider or other

31.1 entity providing health care, navigator, insurance producer, or other entity in the business
31.2 of selling items or services of significant value to or through MNsure. For purposes of this
31.3 paragraph, "health care provider or entity" does not include an academic institution.

31.4 (b) Board members must recuse themselves from discussion of and voting on an
31.5 official matter if the board member has a conflict of interest. A conflict of interest means
31.6 an association including a financial or personal association that has the potential to bias or
31.7 have the appearance of biasing a board member's decisions in matters related to MNsure
31.8 or the conduct of activities under this chapter.

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

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

31.12 Sec. 6. Minnesota Statutes 2014, section 62V.05, subdivision 2, is amended to read:

31.13 Subd. 2. **Operations funding.** (a) ~~Prior to January 1, 2015, MNsure shall retain or~~
31.14 ~~collect up to 1.5 percent of total premiums for individual and small group market health~~
31.15 ~~plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but~~
31.16 ~~the amount collected shall not exceed a dollar amount equal to 25 percent of the funds~~
31.17 ~~collected under section 62E.11, subdivision 6, for calendar year 2012.~~

31.18 (b) ~~Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of~~
31.19 ~~total premiums for individual and small group market health plans and dental plans sold~~
31.20 ~~through MNsure to fund the operations of MNsure, but the amount collected shall not~~
31.21 ~~exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11,~~
31.22 ~~subdivision 6, for calendar year 2012.~~

31.23 (e) ~~Beginning January 1, 2016, through December 31, 2016, MNsure shall retain or~~
31.24 ~~collect up to 3.5 percent of total premiums for individual and small group market health~~
31.25 ~~plans and dental plans sold through MNsure to fund the operations of MNsure, but the~~
31.26 ~~amount collected may never exceed a dollar amount greater than 100 percent of the funds~~
31.27 ~~collected under section 62E.11, subdivision 6, for calendar year 2012.~~

31.28 (d) ~~For fiscal years 2014 and 2015, the commissioner of management and budget is~~
31.29 ~~authorized to provide cash flow assistance of up to \$20,000,000 from the special revenue~~
31.30 ~~fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a),~~
31.31 ~~to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by~~
31.32 ~~June 30, 2015.~~

31.33 (b) Beginning January 1, 2017, through December 31, 2017, MNsure shall retain or
31.34 collect up to 1.75 percent of total premiums for individual and small group market health
31.35 plans and dental plans sold through MNsure to fund the operation of MNsure.

32.1 (c) If an independent third party makes the certification specified in this paragraph,
32.2 MNsure shall retain or collect up to 1.75 percent of total premiums for individual and small
32.3 group market health plans and dental plans sold through MNsure to fund the operations of
32.4 MNsure. This paragraph applies to a calendar year beginning on or after January 1, 2018,
32.5 if in the previous calendar year the independent third party certified that MNsure met all
32.6 of the following operational and technological benchmarks for the previous calendar year:

32.7 (1) on a daily basis, MNsure successfully transferred to health carriers data in the
32.8 EDI 834 format that were complete and accurate according to industry standards and that
32.9 allowed the health carrier to enroll the consumer in the qualified health plan chosen by
32.10 the consumer;

32.11 (2) MNsure automatically processed enrollment renewals in qualified health plans
32.12 and in public health care programs;

32.13 (3) MNsure automatically processed invoices for and payments of MinnesotaCare
32.14 premiums;

32.15 (4) MNsure provided self-service functionality for account changes and changes
32.16 necessitated by qualifying life events, including adding or removing household members,
32.17 making changes to address or income, canceling coverage, and accessing online proof of
32.18 coverage forms required by federal law;

32.19 (5) MNsure transmitted 1095-A forms to enrollees by January 31 each year, or
32.20 earlier if required by federal law; and

32.21 (6) MNsure call center response and resolution times met or exceeded industry
32.22 standards.

32.23 (d) Beginning January 1, 2018, for any calendar year for which the independent
32.24 third party did not make the certification specified in paragraph (c) for the previous
32.25 calendar year, MNsure shall retain or collect up to 1.5 percent of total premiums for
32.26 individual and small group market health plans and dental plans sold through MNsure to
32.27 fund the operation of MNsure.

32.28 (e) Funding for the operations of MNsure shall cover any compensation provided to
32.29 navigators participating in the navigator program.

32.30 (f) The amount collected by MNsure in a calendar year under this subdivision shall
32.31 not exceed a dollar amount greater than 60 percent of the funds collected under section
32.32 62E.11, subdivision 6, for calendar year 2012.

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

32.34 Sec. 7. Minnesota Statutes 2014, section 62V.05, is amended by adding a subdivision
32.35 to read:

33.1 Subd. 12. **Legislative enactment required.** (a) The MNsure board shall not enter
33.2 into or renew any interagency agreement or service level agreement with a value of
33.3 more than \$100,000 a year, or related agreements with a cumulative value of more than
33.4 \$100,000 a year, with a state department, state agency, or the Office of MN.IT Services,
33.5 unless the specific agreement is authorized by enactment of a new law. If an agreement,
33.6 including an agreement in effect as of the effective date of this subdivision, does not have
33.7 an expiration date, the agreement shall expire two years from the effective date of this
33.8 subdivision or the effective date of the agreement, whichever is later, unless the specific
33.9 agreement is authorized by enactment of a new law.

33.10 (b) Notwithstanding section 16A.285, the board shall not transfer appropriations and
33.11 funds in amounts over \$100,000 across agency accounts or programs unless the specific
33.12 transfer is authorized by enactment of a new law.

33.13 (c) For purposes of this subdivision, "state department" has the meaning provided in
33.14 section 15.01, and "state agency" has the meaning provided in section 15.012.

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

33.16 Sec. 8. **[62V.056] MINNESOTA ELIGIBILITY SYSTEM EXECUTIVE**
33.17 **STEERING COMMITTEE.**

33.18 Subdivision 1. **Definition; Minnesota eligibility system.** For purposes of this
33.19 section, "Minnesota eligibility system" means the system that supports eligibility
33.20 determinations using a modified adjusted gross income methodology for medical
33.21 assistance under section 256B.056, subdivision 1a, paragraph (b), clause (1);
33.22 MinnesotaCare under chapter 256L; and qualified health plan enrollment under section
33.23 62V.05, subdivision 5, paragraph (c).

33.24 Subd. 2. **Establishment; committee membership.** The Minnesota Eligibility
33.25 System Executive Steering Committee is established to govern and administer the
33.26 Minnesota eligibility system. The steering committee shall be composed of one member
33.27 appointed by the commissioner of human services, one member appointed by the
33.28 board, one member appointed jointly by the Association of Minnesota Counties and
33.29 the Minnesota Inter-County Association, and one nonvoting member appointed by the
33.30 commissioner of MN.IT services who shall serve as the committee chairperson. Steering
33.31 committee costs must be paid from the budgets of the Department of Human Services, the
33.32 Office of MN.IT Services, and MNsure.

33.33 Subd. 3. **Duties.** (a) The Minnesota Eligibility System Executive Steering
33.34 Committee shall establish an overall governance structure for the Minnesota eligibility
33.35 system and shall be responsible for the overall governance of the system, including setting

34.1 system goals and priorities, allocating the system's resources, making major system
34.2 decisions, and tracking total funding and expenditures for the system from all sources.
34.3 The steering committee shall also report to the Legislative Oversight Committee on a
34.4 quarterly basis on Minnesota eligibility system funding and expenditures, including
34.5 amounts received in the most recent quarter by funding source and expenditures made in
34.6 the most recent quarter by funding source.

34.7 (b) The steering committee shall adopt bylaws, policies, and interagency agreements
34.8 necessary to administer the Minnesota eligibility system.

34.9 (c) In making decisions, the steering committee shall give particular attention to the
34.10 parts of the system with the largest enrollments and the greatest risks.

34.11 Subd. 4. **Meetings.** (a) All meetings of the steering committee must:

34.12 (1) be held in the State Office Building; and

34.13 (2) whenever possible, be available on the legislature's Web site for live streaming
34.14 and downloading over the Internet.

34.15 (b) The steering committee must:

34.16 (1) as part of every steering committee meeting, provide the opportunity for oral
34.17 and written public testimony and comments on steering committee governance of the
34.18 Minnesota eligibility system; and

34.19 (2) provide documents under discussion or review by the steering committee to be
34.20 electronically posted on the legislature's Web site. Documents must be provided and
34.21 posted prior to the meeting at which the documents are scheduled for review or discussion.

34.22 (c) All votes of the steering committee must be recorded, with each member's vote
34.23 identified.

34.24 Subd. 5. **Administrative structure.** The Office of MN.IT Services shall
34.25 be responsible for the design, build, maintenance, operation, and upgrade of the
34.26 information technology for the Minnesota eligibility system. The office shall carry out its
34.27 responsibilities under the governance of the steering committee, this section, and chapter
34.28 16E.

34.29 Sec. 9. Minnesota Statutes 2014, section 62V.11, is amended by adding a subdivision
34.30 to read:

34.31 Subd. 5. **Review of Minnesota eligibility system funding and expenditures.** The
34.32 committee shall review quarterly reports submitted by the Minnesota Eligibility System
34.33 Executive Steering Committee under section 62V.055, subdivision 3, regarding Minnesota
34.34 eligibility system funding and expenditures.

35.1 Sec. 10. Minnesota Statutes 2014, section 144.05, is amended by adding a subdivision
35.2 to read:

35.3 Subd. 6. **Legislative enactment required.** (a) The commissioner of health shall not
35.4 enter into or renew any interagency agreement or service level agreement with a value of
35.5 more than \$100,000 a year, or related agreements with a cumulative value of more than
35.6 \$100,000 a year, with a state department, state agency, or the Office of MN.IT Services,
35.7 unless the specific agreement is authorized by enactment of a new law. If an agreement,
35.8 including an agreement in effect as of the effective date of this subdivision, does not have
35.9 an expiration date, the agreement shall expire two years from the effective date of this
35.10 subdivision or the effective date of the agreement, whichever is later, unless the specific
35.11 agreement is authorized by enactment of a new law.

35.12 (b) Notwithstanding section 16A.285, the commissioner shall not transfer
35.13 appropriations and funds in amounts over \$100,000 across agency accounts or programs
35.14 unless the specific transfer is authorized by enactment of a new law.

35.15 (c) For purposes of this subdivision, "state department" has the meaning provided in
35.16 section 15.01, and "state agency" has the meaning provided in section 15.012.

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

35.18 Sec. 11. Minnesota Statutes 2014, section 256.01, is amended by adding a subdivision
35.19 to read:

35.20 Subd. 41. **Legislative enactment required.** (a) The commissioner of human
35.21 services shall not enter into or renew any interagency agreement or service level agreement
35.22 with a value of more than \$100,000 a year, or related agreements with a cumulative value
35.23 of more than \$100,000 a year, with a state department, state agency, or the Office of
35.24 MN.IT Services, unless the specific agreement is authorized by enactment of a new law. If
35.25 an agreement, including an agreement in effect as of the effective date of this subdivision,
35.26 does not have an expiration date, the agreement shall expire two years from the effective
35.27 date of this subdivision or the effective date of the agreement, whichever is later, unless
35.28 the specific agreement is authorized by enactment of a new law.

35.29 (b) Notwithstanding section 16A.285, the commissioner shall not transfer
35.30 appropriations and funds in amounts over \$100,000 across agency accounts or programs
35.31 unless the specific transfer is authorized by enactment of a new law.

35.32 (c) For purposes of this subdivision, "state department" has the meaning provided in
35.33 section 15.01, and "state agency" has the meaning provided in section 15.012.

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

36.1 Sec. 12. Minnesota Statutes 2014, section 256L.02, is amended by adding a subdivision
36.2 to read:

36.3 Subd. 7. **Federal waiver.** The commissioner shall apply for an innovation waiver
36.4 under section 1332 of the Affordable Care Act, or any other applicable federal waiver, to
36.5 allow persons eligible for MinnesotaCare the option of declining MinnesotaCare coverage
36.6 and instead accessing advanced premium tax credits and cost-sharing reductions through
36.7 the purchase of qualified health plans through MNsure or outside of MNsure directly from
36.8 health plan companies. The commissioner shall submit this federal waiver request within
36.9 nine months of the effective date of this subdivision. The commissioner shall coordinate
36.10 this waiver request with the waiver request required by Laws 2015, chapter 71, article 12,
36.11 section 8. The commissioner shall submit a draft waiver proposal to the MNsure board and
36.12 the chairs and ranking minority members of the legislative committees with jurisdiction
36.13 over health and human services policy and finance at least 30 days before submitting a final
36.14 waiver proposal to the federal government. The commissioner shall notify the board and
36.15 the chairs and ranking minority members of any federal decision or action related to the
36.16 proposal. If federal approval is granted, the commissioner shall submit to the legislature
36.17 draft legislation and fiscal estimates necessary to implement the approved proposal.

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

36.19 Sec. 13. **FEDERAL-STATE ELIGIBILITY DETERMINATION AND**
36.20 **ENROLLMENT SYSTEM FOR INSURANCE AFFORDABILITY PROGRAMS.**

36.21 Subdivision 1. **Waiver request.** (a) The commissioner of human services, in
36.22 consultation with the MNsure board, commissioner of commerce, and commissioner
36.23 of health, shall apply for an innovation waiver under section 1332 of the Affordable
36.24 Care Act, or any other applicable federal waiver, to establish and operate a federal-state
36.25 eligibility determination and enrollment system for state insurance affordability programs
36.26 for coverage beginning January 1, 2018. The federal-state eligibility determination and
36.27 enrollment system shall take the place of MNsure established under Minnesota Statutes,
36.28 chapter 62V. Under the federal-state eligibility determination and enrollment system:

36.29 (1) eligibility determinations and enrollment for persons applying for or renewing
36.30 coverage under medical assistance and MinnesotaCare shall be conducted by the
36.31 commissioner of human services; and

36.32 (2) enrollment in qualified health plans and eligibility determinations for any
36.33 applicable advanced premium tax credits and cost-sharing reductions shall be conducted
36.34 by the federally facilitated marketplace.

37.1 (b) For purposes of this section, "state insurance affordability programs" means
37.2 medical assistance, MinnesotaCare, and qualified health plan coverage with any applicable
37.3 advanced premium tax credits and cost-sharing reductions.

37.4 (c) The federal-state eligibility determination and enrollment system must
37.5 incorporate an asset test for adults without children who qualify for medical assistance
37.6 under Minnesota Statutes, section 256B.055, subdivision 15, or MinnesotaCare under
37.7 Minnesota Statutes, chapter 256L, under which a household of two or more persons must
37.8 not own more than \$20,000 in total net assets and a household of one person must not
37.9 own more than \$10,000 in total net assets.

37.10 Subd. 2. **Requirements of waiver application.** In designing the federal-state
37.11 eligibility determination and enrollment system and developing the waiver application,
37.12 the commissioner shall:

37.13 (1) seek to incorporate, where appropriate and cost-effective, elements of
37.14 the MNsure eligibility determination system and eligibility determination systems
37.15 administered by the commissioner of human services;

37.16 (2) coordinate the waiver request with the waiver requests required by Minnesota
37.17 Statutes, section 256L.02, subdivision 7, if enacted, and with the waiver request required
37.18 by Laws 2015, chapter 71, article 12, section 8;

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

37.22 (4) seek all available federal grants and funds for state planning and development
37.23 costs.

37.24 Subd. 3. **Vendor contract; use of existing resources.** The commissioner of
37.25 human services, in consultation with the chief information officer of MN.IT, may contract
37.26 with a vendor to provide technical assistance in developing the waiver request. The
37.27 commissioner shall develop the waiver request and enter into any contract for technical
37.28 assistance using existing resources.

37.29 Subd. 4. **Reports to legislative committees.** The commissioner of human services
37.30 shall report to the chairs and ranking minority members of the legislative committees with
37.31 jurisdiction over commerce and health and human services policy and finance by January
37.32 1, 2017, on progress in seeking the waiver required by this section, and shall notify these
37.33 chairs and ranking minority members of any federal decision related to the waiver request.

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

37.35 Sec. 14. **REVISOR'S INSTRUCTION.**

38.1 The revisor of statutes shall change cross-references to sections in Minnesota
38.2 Statutes and Minnesota Rules that are repealed in this article when appropriate. The
38.3 revisor may make technical and other necessary changes to sentence structure to preserve
38.4 the meaning of the text.

38.5 Sec. 15. **REPEALER.**

38.6 (a) Minnesota Statutes 2014, sections 62V.01; 62V.02; 62V.03, subdivisions 1 and 3;
38.7 62V.04; 62V.05, subdivisions 1, 2, 3, 4, 5, 9, and 10; 62V.06; 62V.07; 62V.08; 62V.09;
38.8 62V.10; and 62V.11, subdivisions 1, 2, and 4, are repealed.

38.9 (b) Minnesota Statutes 2015 Supplement, sections 62V.03, subdivision 2; 62V.05,
38.10 subdivisions 6, 7, 8, and 11; and 62V.051, are repealed.

38.11 (c) Minnesota Rules, parts 7700.0010; 7700.0020; 7700.0030; 7700.0040;
38.12 7700.0050; 7700.0060; 7700.0070; 7700.0080; 7700.0090; 7700.0100; 7700.0101; and
38.13 7700.0105, are repealed.

38.14 **EFFECTIVE DATE.** This section is effective upon approval of the waiver request
38.15 to establish and operate a federal-state eligibility determination and enrollment system, or
38.16 January 1, 2018, whichever is later. The commissioner of human services shall notify the
38.17 revisor of statutes when the waiver request is approved.

38.18 **ARTICLE 4**

38.19 **HEALTH DEPARTMENT**

38.20 Section 1. Minnesota Statutes 2014, section 13.3805, is amended by adding a
38.21 subdivision to read:

38.22 **Subd. 5. Radon testing and mitigation data.** Data maintained by the Department
38.23 of Health that identify the address of a radon testing or mitigation site, and the name,
38.24 address, e-mail address, and telephone number of residents and residential property owners
38.25 of a radon testing or mitigation site, are private data on individuals or nonpublic data.

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

38.27 Sec. 2. Minnesota Statutes 2014, section 62J.495, subdivision 4, is amended to read:

38.28 **Subd. 4. Coordination with national HIT activities.** (a) The commissioner,
38.29 in consultation with the e-Health Advisory Committee, shall update the statewide
38.30 implementation plan required under subdivision 2 and released June 2008, to be consistent
38.31 with the updated Federal HIT Strategic Plan released by the Office of the National

39.1 Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan
39.2 shall meet the requirements for a plan required under section 3013 of the HITECH Act.

39.3 (b) The commissioner, in consultation with the e-Health Advisory Committee,
39.4 shall work to ensure coordination between state, regional, and national efforts to support
39.5 and accelerate efforts to effectively use health information technology to improve the
39.6 quality and coordination of health care and the continuity of patient care among health
39.7 care providers, to reduce medical errors, to improve population health, to reduce health
39.8 disparities, and to reduce chronic disease. The commissioner's coordination efforts shall
39.9 include but not be limited to:

39.10 (1) assisting in the development and support of health information technology
39.11 regional extension centers established under section 3012(c) of the HITECH Act to
39.12 provide technical assistance and disseminate best practices; and

39.13 (2) providing supplemental information to the best practices gathered by regional
39.14 centers to ensure that the information is relayed in a meaningful way to the Minnesota
39.15 health care community;

39.16 (3) providing financial and technical support to Minnesota health care providers to
39.17 encourage implementation of admission, discharge, and transfer alerts and care summary
39.18 document exchange transactions, and to evaluate the impact of health information
39.19 technology on cost and quality of care. Communications about available financial and
39.20 technical support shall include clear information about the interoperable electronic health
39.21 record requirements in subdivision 1, including a separate statement in boldface type
39.22 clarifying the exceptions to those requirements;

39.23 (4) providing educational resources and technical assistance to health care providers
39.24 and patients related to state and national privacy, security, and consent laws governing
39.25 clinical health information, including the requirements of sections 144.291 to 144.298. In
39.26 carrying out these activities, the commissioner's technical assistance does not constitute
39.27 legal advice; and

39.28 (5) assessing Minnesota's legal, financial, and regulatory framework for health
39.29 information exchange, including the requirements of sections 144.291 to 144.298, and
39.30 making recommendations for modifications that would strengthen the ability of Minnesota
39.31 health care providers to securely exchange data in compliance with patient preferences
39.32 and in a way that is efficient and financially sustainable.

39.33 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall
39.34 monitor national activity related to health information technology and shall coordinate
39.35 statewide input on policy development. The commissioner shall coordinate statewide
39.36 responses to proposed federal health information technology regulations in order to ensure

40.1 that the needs of the Minnesota health care community are adequately and efficiently
40.2 addressed in the proposed regulations. The commissioner's responses may include, but
40.3 are not limited to:

40.4 (1) reviewing and evaluating any standard, implementation specification, or
40.5 certification criteria proposed by the national HIT standards committee;

40.6 (2) reviewing and evaluating policy proposed by the national HIT policy committee
40.7 relating to the implementation of a nationwide health information technology infrastructure;

40.8 (3) monitoring and responding to activity related to the development of quality
40.9 measures and other measures as required by section 4101 of the HITECH Act. Any
40.10 response related to quality measures shall consider and address the quality efforts required
40.11 under chapter 62U; and

40.12 (4) monitoring and responding to national activity related to privacy, security, and
40.13 data stewardship of electronic health information and individually identifiable health
40.14 information.

40.15 (d) To the extent that the state is either required or allowed to apply, or designate an
40.16 entity to apply for or carry out activities and programs under section 3013 of the HITECH
40.17 Act, the commissioner of health, in consultation with the e-Health Advisory Committee
40.18 and the commissioner of human services, shall be the lead applicant or sole designating
40.19 authority. The commissioner shall make such designations consistent with the goals and
40.20 objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

40.21 (e) The commissioner of human services shall apply for funding necessary to
40.22 administer the incentive payments to providers authorized under title IV of the American
40.23 Recovery and Reinvestment Act.

40.24 (f) The commissioner shall include in the report to the legislature information on the
40.25 activities of this subdivision and provide recommendations on any relevant policy changes
40.26 that should be considered in Minnesota.

40.27 Sec. 3. Minnesota Statutes 2014, section 62J.496, subdivision 1, is amended to read:

40.28 Subdivision 1. **Account establishment.** (a) An account is established to:

40.29 (1) finance the purchase of certified electronic health records or qualified electronic
40.30 health records as defined in section 62J.495, subdivision 1a;

40.31 (2) enhance the utilization of electronic health record technology, which may include
40.32 costs associated with upgrading the technology to meet the criteria necessary to be a
40.33 certified electronic health record or a qualified electronic health record;

40.34 (3) train personnel in the use of electronic health record technology; and

40.35 (4) improve the secure electronic exchange of health information.

41.1 (b) Amounts deposited in the account, including any grant funds obtained through
41.2 federal or other sources, loan repayments, and interest earned on the amounts shall
41.3 be used only for awarding loans or loan guarantees, as a source of reserve and security
41.4 for leveraged loans, for activities authorized in section 62J.495, subdivision 4, or for
41.5 the administration of the account.

41.6 (c) The commissioner may accept contributions to the account from private sector
41.7 entities subject to the following provisions:

41.8 (1) the contributing entity may not specify the recipient or recipients of any loan
41.9 issued under this subdivision;

41.10 (2) the commissioner shall make public the identity of any private contributor to the
41.11 loan fund, as well as the amount of the contribution provided;

41.12 (3) the commissioner may issue letters of commendation or make other awards that
41.13 have no financial value to any such entity; and

41.14 (4) a contributing entity may not specify that the recipient or recipients of any loan
41.15 use specific products or services, nor may the contributing entity imply that a contribution
41.16 is an endorsement of any specific product or service.

41.17 (d) The commissioner may use the loan funds to reimburse private sector entities
41.18 for any contribution made to the loan fund. Reimbursement to private entities may not
41.19 exceed the principle amount contributed to the loan fund.

41.20 (e) The commissioner may use funds deposited in the account to guarantee, or
41.21 purchase insurance for, a local obligation if the guarantee or purchase would improve
41.22 credit market access or reduce the interest rate applicable to the obligation involved.

41.23 (f) The commissioner may use funds deposited in the account as a source of revenue
41.24 or security for the payment of principal and interest on revenue or general obligation
41.25 bonds issued by the state if the proceeds of the sale of the bonds will be deposited into
41.26 the loan fund.

41.27 (h) The commissioner shall not award new loans or loan guarantees after July 1, 2016.

41.28 Sec. 4. **[144.1912] GREATER MINNESOTA FAMILY MEDICINE RESIDENCY**
41.29 **GRANT PROGRAM.**

41.30 Subdivision 1. Definitions. (a) For purposes of this section, the following terms
41.31 have the meanings given.

41.32 (b) "Commissioner" means the commissioner of health.

41.33 (c) "Eligible family medicine residency program" means a program that meets the
41.34 following criteria:

42.1 (1) is located in Minnesota outside the seven-county metropolitan area as defined in
42.2 section 473.121, subdivision 4;

42.3 (2) is accredited as a family medicine residency program or is a candidate for
42.4 accreditation;

42.5 (3) is focused on the education and training of family medicine physicians to serve
42.6 communities outside the metropolitan area; and

42.7 (4) demonstrates that over the most recent three years, at least 25 percent of its
42.8 graduates practice in Minnesota communities outside the metropolitan area.

42.9 Subd. 2. **Program administration.** (a) The commissioner shall award family
42.10 medicine residency grants to existing, eligible, not-for-profit family medicine residency
42.11 programs to support current and new residency positions. Funds shall be allocated first to
42.12 proposed new family medicine residency positions, and remaining funds shall be allocated
42.13 proportionally based on the number of existing residents in eligible programs. The
42.14 commissioner may fund a new residency position for up to three years.

42.15 (b) Grant funds awarded may only be spent to cover the costs of:

42.16 (1) establishing, maintaining, or expanding training for family medicine residents;

42.17 (2) recruitment, training, and retention of residents and faculty;

42.18 (3) travel and lodging for residents; and

42.19 (4) faculty, resident, and preceptor salaries.

42.20 (c) Grant funds shall not be used to supplant any other government or private funds
42.21 available for these purposes.

42.22 Subd. 3. **Applications.** Eligible family medicine residency programs seeking a
42.23 grant must apply to the commissioner. The application must include objectives, a related
42.24 work plan and budget, a description of the number of new and existing residency positions
42.25 that will be supported using grant funds, and additional information the commissioner
42.26 determines to be necessary. The commissioner shall determine whether applications are
42.27 complete and responsive and may require revisions or additional information before
42.28 awarding a grant.

42.29 Subd. 4. **Program oversight.** The commissioner may require and collect from
42.30 family medicine residency programs receiving grants any information necessary to
42.31 administer and evaluate the program.

42.32 Sec. 5. Minnesota Statutes 2014, section 144.293, subdivision 2, is amended to read:

42.33 Subd. 2. **Patient consent to release of records.** (a) A provider, or a person who
42.34 receives health records from a provider, may not release a patient's health records to a
42.35 person without:

43.1 (1) a signed and dated consent from the patient or the patient's legally authorized
43.2 representative authorizing the release;

43.3 (2) specific authorization in law; or

43.4 (3) a representation from a provider that holds a signed and dated consent from the
43.5 patient authorizing the release.

43.6 (b) Any consent form signed by a patient must include an option to indicate "yes" or
43.7 "no" to individual items for which the provider is requesting consent. The provider may not
43.8 condition the patient's receipt of treatment on the patient's willingness to release records.

43.9 Sec. 6. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 3, is
43.10 amended to read:

43.11 Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules for establishing
43.12 licensure requirements and enforcement of applicable laws and rules work standards
43.13 relating to indoor radon in dwellings and other buildings, with the exception of newly
43.14 constructed Minnesota homes according to section 326B.106, subdivision 6. The
43.15 commissioner shall coordinate, oversee, and implement all state functions in matters
43.16 concerning the presence, effects, measurement, and mitigation of risks of radon in
43.17 dwellings and other buildings.

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

43.19 Sec. 7. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 4, is
43.20 amended to read:

43.21 Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or
43.22 after ~~October 1, 2017~~ January 1, 2018, must have a radon mitigation system tag provided
43.23 by the commissioner. A radon mitigation professional must attach the tag to the radon
43.24 mitigation system in a visible location.

43.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

43.26 Sec. 8. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 5, is
43.27 amended to read:

43.28 Subd. 5. **License required annually.** A license is required annually for every
43.29 person, firm, or corporation that ~~sells a device or~~ performs a service for compensation
43.30 to detect the presence of radon in the indoor atmosphere, performs laboratory analysis,
43.31 or performs a service to mitigate radon in the indoor atmosphere. ~~This section does not~~

44.1 ~~apply to retail stores that only sell or distribute radon sampling but are not engaged in the~~
44.2 ~~manufacture of radon sampling devices.~~

44.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

44.4 Sec. 9. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 6, is
44.5 amended to read:

44.6 Subd. 6. **Exemptions.** This section does not apply to:

44.7 (1) radon control systems installed in newly constructed Minnesota homes according
44.8 to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy are
44.9 not required to follow the requirements of this section;

44.10 (2) employees of a firm or corporation that installs radon control systems in newly
44.11 constructed Minnesota homes specified in clause (1);

44.12 (3) a person authorized as a building official under Minnesota Rules, part 1300.0110,
44.13 or that person's designee; or

44.14 (4) any person, firm, corporation, or entity that distributes radon testing devices or
44.15 information for general educational purposes.

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

44.17 Sec. 10. Minnesota Statutes 2015 Supplement, section 144.4961, subdivision 8,
44.18 is amended to read:

44.19 Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the
44.20 commissioner of health must be accompanied by the required fees. If the commissioner
44.21 determines that insufficient fees were paid, the necessary additional fees must be paid
44.22 before the commissioner approves the application. The commissioner shall charge the
44.23 following fees for each radon license:

44.24 (1) Each measurement professional license, ~~\$300~~ \$150 per year. "Measurement
44.25 professional" means any person who performs a test to determine the presence and
44.26 concentration of radon in a building ~~they do~~ the person does not own or lease; ~~provides~~
44.27 ~~professional or expert advice on radon testing, radon exposure, or health risks related to~~
44.28 ~~radon exposure; or makes representations of doing any of these activities.~~

44.29 (2) Each mitigation professional license, ~~\$500~~ \$250 per year. "Mitigation
44.30 professional" means an individual who ~~performs~~ installs or designs a radon mitigation
44.31 system in a building ~~they do~~ the individual does not own or lease; ~~provides professional or~~
44.32 ~~expert advice on radon mitigation or radon entry routes; or provides on-site supervision~~
44.33 ~~of radon mitigation and mitigation technicians; or makes representations of doing any of~~

45.1 ~~these activities.~~ "On-site supervision" means a review at the property of mitigation work
45.2 upon completion of the work and attachment of a system tag. Employees or subcontractors
45.3 who are supervised by a licensed mitigation professional are not required to be licensed
45.4 under this clause. This license also permits the licensee to perform the activities of a
45.5 measurement professional described in clause (1).

45.6 (3) Each mitigation company license, ~~\$500~~ \$100 per year. "Mitigation company"
45.7 means any business or government entity that performs or authorizes employees to
45.8 perform radon mitigation. This fee is waived if the mitigation company is a sole
45.9 proprietorship employs only one licensed mitigation professional.

45.10 (4) Each radon analysis laboratory license, \$500 per year. "Radon analysis
45.11 laboratory" means a business entity or government entity that analyzes passive radon
45.12 detection devices to determine the presence and concentration of radon in the devices.
45.13 This fee is waived if the laboratory is a government entity and is only distributing test kits
45.14 for the general public to use in Minnesota.

45.15 (5) Each Minnesota Department of Health radon mitigation system tag, \$75 per tag.
45.16 "Minnesota Department of Health radon mitigation system tag" or "system tag" means a
45.17 unique identifiable radon system label provided by the commissioner of health.

45.18 (b) Fees collected under this section shall be deposited in the state treasury and
45.19 credited to the state government special revenue fund.

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

45.21 Sec. 11. Minnesota Statutes 2015 Supplement, section 144.4961, is amended by adding
45.22 a subdivision to read:

45.23 Subd. 10. **Local inspections or permits.** This section does not preclude local units
45.24 of government from requiring additional permits or inspections for radon control systems,
45.25 and does not supersede any local inspection or permit requirements.

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

45.27 Sec. 12. **[144.7011] PRESCRIPTION DRUG PRICE REPORTING.**

45.28 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
45.29 apply.

45.30 (b) "Available discount" means any reduction in the usual and customary price
45.31 offered for a 30-day supply of a prescription drug to individuals in Minnesota regardless
45.32 of their health insurance coverage.

46.1 (c) "Retail pharmacy" means any pharmacy licensed under section 151.19, and in
46.2 the community/outpatient category under Minnesota Rules, part 6800.0350, that has a
46.3 physical presence in Minnesota.

46.4 (d) "Retail price" means the price maintained by pharmacies as the usual and
46.5 customary price offered for a 30-day supply to individuals in Minnesota regardless of
46.6 the individual's health insurance coverage.

46.7 Subd. 2. **Prescription drug price information reporting.** By July 1, 2017, the
46.8 commissioner of health shall establish an interactive Web site that allows retail pharmacies,
46.9 on a voluntary basis, to list retail prices and available discounts for one or more of the 150
46.10 most commonly dispensed prescription drugs in Minnesota. The Web site must report the
46.11 retail prices for prescription drugs by participating pharmacy and any time period restriction
46.12 on an available discount. The Web site must allow consumers to search for prescription
46.13 drug retail prices by drug name and class, by available discount level, and by city, county,
46.14 and zip code. The commissioner shall consult annually with the commissioner of human
46.15 services to determine the list of the 150 most commonly filled prescription drugs, based on
46.16 prescription drug utilization in the medical assistance and MinnesotaCare programs.

46.17 Subd. 3. **Pharmacy duties.** Beginning on June 1, 2017, and on a monthly basis
46.18 thereafter, all participating retail pharmacies shall submit retail prices and available
46.19 discounts to the commissioner using a form developed by the commissioner. A
46.20 retail pharmacy may opt out of the reporting system at any time, but shall notify the
46.21 commissioner at least 60 days prior to opting out.

46.22 Subd. 4. **External vendors.** In carrying out the duties of this section, the
46.23 commissioner may contract with an outside vendor for collection of data from pharmacies,
46.24 and may also contract with an outside vendor for development and hosting of the
46.25 interactive application, if this contract complies with the requirements of section 16E.016,
46.26 paragraph (c).

46.27 Subd. 5. **Grounds for disciplinary action.** If the commissioner determines
46.28 that a pharmacy has reported false or inaccurate information under this section, the
46.29 commissioner may report this action to the Minnesota Board of Pharmacy as potential
46.30 grounds for disciplinary action under section 151.071, subdivision 2, clause (9).

46.31 Sec. 13. Minnesota Statutes 2014, section 144A.471, subdivision 9, is amended to read:

46.32 **Subd. 9. Exclusions from home care licensure.** The following are excluded from
46.33 home care licensure and are not required to provide the home care bill of rights:

46.34 (1) an individual or business entity providing only coordination of home care that
46.35 includes one or more of the following:

- 47.1 (i) determination of whether a client needs home care services, or assisting a client
47.2 in determining what services are needed;
- 47.3 (ii) referral of clients to a home care provider;
- 47.4 (iii) administration of payments for home care services; or
- 47.5 (iv) administration of a health care home established under section 256B.0751;
- 47.6 (2) an individual who is not an employee of a licensed home care provider if the
47.7 individual:
- 47.8 (i) only provides services as an independent contractor to one or more licensed
47.9 home care providers;
- 47.10 (ii) provides no services under direct agreements or contracts with clients; and
- 47.11 (iii) is contractually bound to perform services in compliance with the contracting
47.12 home care provider's policies and service plans;
- 47.13 (3) a business that provides staff to home care providers, such as a temporary
47.14 employment agency, if the business:
- 47.15 (i) only provides staff under contract to licensed or exempt providers;
- 47.16 (ii) provides no services under direct agreements with clients; and
- 47.17 (iii) is contractually bound to perform services under the contracting home care
47.18 provider's direction and supervision;
- 47.19 (4) any home care services conducted by and for the adherents of any recognized
47.20 church or religious denomination for its members through spiritual means, or by prayer
47.21 for healing;
- 47.22 (5) an individual who only provides home care services to a relative;
- 47.23 (6) an individual not connected with a home care provider that provides assistance
47.24 with basic home care needs if the assistance is provided primarily as a contribution and
47.25 not as a business;
- 47.26 (7) an individual not connected with a home care provider that shares housing with
47.27 and provides primarily housekeeping or homemaking services to an elderly or disabled
47.28 person in return for free or reduced-cost housing;
- 47.29 (8) an individual or provider providing home-delivered meal services;
- 47.30 (9) an individual providing senior companion services and other older American
47.31 volunteer programs (OAVP) established under the Domestic Volunteer Service Act of
47.32 1973, United States Code, title 42, chapter 66;
- 47.33 (10) an employee of a nursing home or home care provider licensed under this
47.34 chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56
47.35 who responds to occasional emergency calls from individuals residing in a residential

48.1 setting that is attached to or located on property contiguous to the nursing home or,
48.2 boarding care home, or location where home care services are also provided;

48.3 (11) an employee of a nursing home or home care provider licensed under this
48.4 chapter or an employee of a boarding care home licensed under sections 144.50 to
48.5 144.56 who provides occasional minor services free of charge to individuals residing in
48.6 a residential setting that is attached to or located on property contiguous to the nursing
48.7 home, boarding care home, or location where home care services are also provided, for the
48.8 occasional minor services provided free of charge;

48.9 ~~(11)~~ (12) a member of a professional corporation organized under chapter 319B that
48.10 does not regularly offer or provide home care services as defined in section 144A.43,
48.11 subdivision 3;

48.12 ~~(12)~~ (13) the following organizations established to provide medical or surgical
48.13 services that do not regularly offer or provide home care services as defined in section
48.14 144A.43, subdivision 3: a business trust organized under sections 318.01 to 318.04,
48.15 a nonprofit corporation organized under chapter 317A, a partnership organized under
48.16 chapter 323, or any other entity determined by the commissioner;

48.17 ~~(13)~~ (14) an individual or agency that provides medical supplies or durable medical
48.18 equipment, except when the provision of supplies or equipment is accompanied by a
48.19 home care service;

48.20 ~~(14)~~ (15) a physician licensed under chapter 147;

48.21 ~~(15)~~ (16) an individual who provides home care services to a person with a
48.22 developmental disability who lives in a place of residence with a family, foster family, or
48.23 primary caregiver;

48.24 ~~(16)~~ (17) a business that only provides services that are primarily instructional and
48.25 not medical services or health-related support services;

48.26 ~~(17)~~ (18) an individual who performs basic home care services for no more than
48.27 14 hours each calendar week to no more than one client;

48.28 ~~(18)~~ (19) an individual or business licensed as hospice as defined in sections 144A.75
48.29 to 144A.755 who is not providing home care services independent of hospice service;

48.30 ~~(19)~~ (20) activities conducted by the commissioner of health or a community health
48.31 board as defined in section 145A.02, subdivision 5, including communicable disease
48.32 investigations or testing; or

48.33 ~~(20)~~ (21) administering or monitoring a prescribed therapy necessary to control or
48.34 prevent a communicable disease, or the monitoring of an individual's compliance with a
48.35 health directive as defined in section 144.4172, subdivision 6.

49.1 Sec. 14. Minnesota Statutes 2014, section 144A.75, subdivision 5, is amended to read:

49.2 Subd. 5. **Hospice provider.** "Hospice provider" means an individual, organization,
49.3 association, corporation, unit of government, or other entity that is regularly engaged
49.4 in the delivery, directly or by contractual arrangement, of hospice services for a fee to
49.5 ~~terminally ill~~ hospice patients. A hospice must provide all core services.

49.6 Sec. 15. Minnesota Statutes 2014, section 144A.75, subdivision 6, is amended to read:

49.7 Subd. 6. **Hospice patient.** "Hospice patient" means an individual ~~who has been~~
49.8 ~~diagnosed as terminally ill, with a probable life expectancy of under one year, as whose~~
49.9 illness has been documented by the individual's attending physician and hospice medical
49.10 director, who alone or, when unable, through the individual's family has voluntarily
49.11 consented to and received admission to a hospice provider, and who:

49.12 (1) has been diagnosed as terminally ill, with a probable life expectancy of under
49.13 one year; or

49.14 (2) is 21 years of age or younger; has been diagnosed with a chronic, complex, and
49.15 life-threatening illness contributing to a shortened life expectancy; and is not expected
49.16 to survive to adulthood.

49.17 Sec. 16. Minnesota Statutes 2014, section 144A.75, subdivision 8, is amended to read:

49.18 Subd. 8. **Hospice services; hospice care.** "Hospice services" or "hospice care"
49.19 means palliative and supportive care and other services provided by an interdisciplinary
49.20 team under the direction of an identifiable hospice administration to ~~terminally ill~~ hospice
49.21 patients and their families to meet the physical, nutritional, emotional, social, spiritual,
49.22 and special needs experienced during the final stages of illness, dying, and bereavement,
49.23 or during a chronic, complex, and life-threatening illness contributing to a shortened life
49.24 expectancy. These services are provided through a centrally coordinated program that
49.25 ensures continuity and consistency of home and inpatient care that is provided directly
49.26 or through an agreement.

49.27 Sec. 17. Minnesota Statutes 2015 Supplement, section 144A.75, subdivision 13,
49.28 is amended to read:

49.29 Subd. 13. **Residential hospice facility.** (a) "Residential hospice facility" means a
49.30 facility that resembles a single-family home modified to address life safety, accessibility,
49.31 and care needs, located in a residential area that directly provides 24-hour residential
49.32 and support services in a home-like setting for hospice patients as an integral part of the
49.33 continuum of home care provided by a hospice and that houses:

50.1 (1) no more than eight hospice patients; or
50.2 (2) at least nine and no more than 12 hospice patients with the approval of the local
50.3 governing authority, notwithstanding section 462.357, subdivision 8.

50.4 (b) Residential hospice facility also means a facility that directly provides 24-hour
50.5 residential and support services for hospice patients and that:

50.6 (1) houses no more than 21 hospice patients;
50.7 (2) meets hospice certification regulations adopted pursuant to title XVIII of the
50.8 federal Social Security Act, United States Code, title 42, section 1395, et seq.; and
50.9 (3) is located on St. Anthony Avenue in St. Paul, Minnesota, and was licensed as a
50.10 40-bed non-Medicare certified nursing home as of January 1, 2015.

50.11 Sec. 18. Minnesota Statutes 2014, section 144A.75, is amended by adding a
50.12 subdivision to read:

50.13 Subd. 13a. **Respite care.** "Respite care" means short-term care in an inpatient
50.14 facility, such as a residential hospice facility, when necessary to relieve the hospice
50.15 patient's family or other persons caring for the patient. Respite care may be provided on
50.16 an occasional basis.

50.17 Sec. 19. Minnesota Statutes 2015 Supplement, section 145.4131, subdivision 1,
50.18 is amended to read:

50.19 Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall
50.20 prepare a reporting form for use by physicians or facilities performing abortions. A copy
50.21 of this section shall be attached to the form. A physician or facility performing an abortion
50.22 shall obtain a form from the commissioner.

50.23 (b) The form shall require the following information:

50.24 (1) the number of abortions performed by the physician in the previous calendar
50.25 year, reported by month;

50.26 (2) the method used for each abortion;

50.27 (3) the approximate gestational age expressed in one of the following increments:

50.28 (i) less than nine weeks;

50.29 (ii) nine to ten weeks;

50.30 (iii) 11 to 12 weeks;

50.31 (iv) 13 to 15 weeks;

50.32 (v) 16 to 20 weeks;

50.33 (vi) 21 to 24 weeks;

50.34 (vii) 25 to 30 weeks;

- 51.1 (viii) 31 to 36 weeks; or
- 51.2 (ix) 37 weeks to term;
- 51.3 (4) the age of the woman at the time the abortion was performed;
- 51.4 (5) the specific reason for the abortion, including, but not limited to, the following:
- 51.5 (i) the pregnancy was a result of rape;
- 51.6 (ii) the pregnancy was a result of incest;
- 51.7 (iii) economic reasons;
- 51.8 (iv) the woman does not want children at this time;
- 51.9 (v) the woman's emotional health is at stake;
- 51.10 (vi) the woman's physical health is at stake;
- 51.11 (vii) the woman will suffer substantial and irreversible impairment of a major bodily
- 51.12 function if the pregnancy continues;
- 51.13 (viii) the pregnancy resulted in fetal anomalies; or
- 51.14 (ix) unknown or the woman refused to answer;
- 51.15 (6) the number of prior induced abortions;
- 51.16 (7) the number of prior spontaneous abortions;
- 51.17 (8) whether the abortion was paid for by:
- 51.18 (i) private coverage;
- 51.19 (ii) public assistance health coverage; or
- 51.20 (iii) self-pay;
- 51.21 (9) whether coverage was under:
- 51.22 (i) a fee-for-service plan;
- 51.23 (ii) a capitated private plan; or
- 51.24 (iii) other;
- 51.25 (10) complications, if any, for each abortion and for the aftermath of each abortion.
- 51.26 Space for a description of any complications shall be available on the form;
- 51.27 (11) the medical specialty of the physician performing the abortion; ~~and~~
- 51.28 (12) if the abortion was performed via telemedicine, the facility code for the patient
- 51.29 and the facility code for the physician; and
- 51.30 ~~(12)~~ (13) whether the abortion resulted in a born alive infant, as defined in section
- 51.31 145.423, subdivision 4, and:
- 51.32 (i) any medical actions taken to preserve the life of the born alive infant;
- 51.33 (ii) whether the born alive infant survived; and
- 51.34 (iii) the status of the born alive infant, should the infant survive, if known.
- 51.35 **EFFECTIVE DATE.** This section is effective January 1, 2017.

52.1 Sec. 20. Minnesota Statutes 2014, section 145.4716, subdivision 2, is amended to read:

52.2 Subd. 2. **Duties of director.** The director of child sex trafficking prevention is
52.3 responsible for the following:

52.4 (1) developing and providing comprehensive training on sexual exploitation of
52.5 youth for social service professionals, medical professionals, public health workers, and
52.6 criminal justice professionals;

52.7 (2) collecting, organizing, maintaining, and disseminating information on sexual
52.8 exploitation and services across the state, including maintaining a list of resources on the
52.9 Department of Health Web site;

52.10 (3) monitoring and applying for federal funding for antitrafficking efforts that may
52.11 benefit victims in the state;

52.12 (4) managing grant programs established under sections 145.4716 to 145.4718
52.13 and 609.3241, paragraph (c), clause (3);

52.14 (5) managing the request for proposals for grants for comprehensive services,
52.15 including trauma-informed, culturally specific services;

52.16 (6) identifying best practices in serving sexually exploited youth, as defined in
52.17 section 260C.007, subdivision 31;

52.18 (7) providing oversight of and technical support to regional navigators pursuant to
52.19 section 145.4717;

52.20 (8) conducting a comprehensive evaluation of the statewide program for safe harbor
52.21 of sexually exploited youth; and

52.22 (9) developing a policy consistent with the requirements of chapter 13 for sharing
52.23 data related to sexually exploited youth, as defined in section 260C.007, subdivision 31,
52.24 among regional navigators and community-based advocates.

52.25 Sec. 21. Minnesota Statutes 2014, section 145.4716, is amended by adding a
52.26 subdivision to read:

52.27 Subd. 3. **Youth eligible for services.** Youth 24 years of age or younger shall be
52.28 eligible for all services, support, and programs provided under this section and section
52.29 145.4717, and all shelter, housing beds, and services provided by the commissioner of
52.30 human services to sexually exploited youth and youth at risk of sexual exploitation.

52.31 Sec. 22. **[145.908] GRANT PROGRAM; SCREENING AND TREATMENT FOR**
52.32 **PRE- AND POSTPARTUM MOOD AND ANXIETY DISORDERS.**

52.33 Subdivision 1. **Grant program established.** Within the limits of federal funds
52.34 available specifically for this purpose, the commissioner of health shall establish a grant

53.1 program to provide culturally competent programs to screen and treat pregnant women
 53.2 and women who have given birth in the preceding 12 months for pre- and postpartum
 53.3 mood and anxiety disorders. Organizations may use grant funds to establish new screening
 53.4 or treatment programs, or expand or maintain existing screening or treatment programs. In
 53.5 establishing the grant program, the commissioner shall prioritize expanding or enhancing
 53.6 screening for pre- and postpartum mood and anxiety disorders in primary care settings.
 53.7 The commissioner shall determine the types of organizations eligible for grants.

53.8 Subd. 2. **Allowable uses of funds.** Grant funds awarded by the commissioner
 53.9 under this section:

53.10 (1) must be used to provide health care providers with appropriate training
 53.11 and relevant resources on screening, treatment, follow-up support, and links to
 53.12 community-based resources for pre- and postpartum mood and anxiety disorders; and

53.13 (2) may be used to:

53.14 (i) enable health care providers to provide or receive psychiatric consultations to
 53.15 treat eligible women for pre- and postpartum mood and anxiety disorders;

53.16 (ii) conduct a public awareness campaign;

53.17 (iii) fund startup costs for telephone lines, Web sites, and other resources to collect
 53.18 and disseminate information about screening and treatment for pre- and postpartum mood
 53.19 and anxiety disorders; or

53.20 (iv) establish connections between community-based resources.

53.21 Subd. 3. **Federal funds.** The commissioner shall apply for any available grant funds
 53.22 from the federal Department of Health and Human Services for this program.

53.23 Sec. 23. Minnesota Statutes 2014, section 149A.50, subdivision 2, is amended to read:

53.24 Subd. 2. **Requirements for funeral establishment.** A funeral establishment
 53.25 licensed under this section must:

53.26 (1) ~~contain a~~ comply with preparation and embalming room requirements as
 53.27 described in section 149A.92;

53.28 (2) contain office space for making arrangements; and

53.29 (3) comply with applicable local and state building codes, zoning laws, and
 53.30 ordinances.

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

53.32 Sec. 24. Minnesota Statutes 2015 Supplement, section 149A.92, subdivision 1, is
 53.33 amended to read:

54.1 Subdivision 1. **Establishment update.** ~~(a) Notwithstanding subdivision 11, a~~
 54.2 ~~funeral establishment with other establishment locations that uses one preparation and~~
 54.3 ~~embalming room for all establishment locations has until July 1, 2017, to bring the other~~
 54.4 ~~establishment locations that are not used for preparation or embalming into compliance~~
 54.5 ~~with this section so long as the preparation and embalming room that is used complies~~
 54.6 ~~with the minimum standards in this section.~~

54.7 ~~(b) At the time that ownership of a funeral establishment changes, the physical~~
 54.8 ~~location of the establishment changes, or the building housing the funeral establishment or~~
 54.9 ~~business space of the establishment is remodeled the existing preparation and embalming~~
 54.10 ~~room must be brought into compliance with the minimum standards in this section and in~~
 54.11 ~~accordance with subdivision 11.~~

54.12 (a) Any room used by a funeral establishment for preparation and embalming must
 54.13 comply with the minimum standards of this section. A funeral establishment where no
 54.14 preparation and embalming is performed, but which conducts viewings, visitations, and
 54.15 services, or which holds human remains while awaiting final disposition, need not comply
 54.16 with the minimum standards of this section.

54.17 (b) Each funeral establishment must have a preparation and embalming room that
 54.18 complies with the minimum standards of this section, except that a funeral establishment
 54.19 that operates branch locations need only have one compliant preparation and embalming
 54.20 room for all locations.

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

54.22 Sec. 25. Minnesota Statutes 2014, section 157.15, subdivision 14, is amended to read:

54.23 Subd. 14. **Special event food stand.** "Special event food stand" means a food and
 54.24 beverage service establishment which is used in conjunction with celebrations and special
 54.25 events, and which operates ~~no more than three times annually~~ for no more than ten total
 54.26 days within the applicable license period.

54.27 Sec. 26. Minnesota Statutes 2014, section 327.14, subdivision 9, is amended to read:

54.28 Subd. 9. **Special event recreational camping area.** "Special event recreational
 54.29 camping area" means a recreational camping area which operates no more than two times
 54.30 annually and for no more than 14 consecutive days. Special event camping does not
 54.31 include any club, group, organization, or association that in the course of its operations
 54.32 sponsors an event that includes camping where that camping event portrays or deals with
 54.33 historical reenactments or the history and culture of Minnesota or the United States of
 54.34 America, or is of educational value.

55.1 Sec. 27. Minnesota Statutes 2014, section 609.3241, is amended to read:

55.2 **609.3241 PENALTY ASSESSMENT AUTHORIZED.**

55.3 (a) When a court sentences an adult convicted of violating section 609.322 or
55.4 609.324, while acting other than as a prostitute, the court shall impose an assessment of
55.5 not less than \$500 and not more than \$750 for a violation of section 609.324, subdivision
55.6 2, or a misdemeanor violation of section 609.324, subdivision 3; otherwise the court shall
55.7 impose an assessment of not less than \$750 and not more than \$1,000. The assessment
55.8 shall be distributed as provided in paragraph (c) and is in addition to the surcharge
55.9 required by section 357.021, subdivision 6.

55.10 (b) The court may not waive payment of the minimum assessment required by
55.11 this section. If the defendant qualifies for the services of a public defender or the court
55.12 finds on the record that the convicted person is indigent or that immediate payment of
55.13 the assessment would create undue hardship for the convicted person or that person's
55.14 immediate family, the court may reduce the amount of the minimum assessment to not
55.15 less than \$100. The court also may authorize payment of the assessment in installments.

55.16 (c) The assessment collected under paragraph (a) must be distributed as follows:

55.17 (1) 40 percent of the assessment shall be forwarded to the political subdivision that
55.18 employs the arresting officer for use in enforcement, training, and education activities
55.19 related to combating sexual exploitation of youth, or if the arresting officer is an employee
55.20 of the state, this portion shall be forwarded to the commissioner of public safety for those
55.21 purposes identified in clause (3);

55.22 (2) 20 percent of the assessment shall be forwarded to the prosecuting agency that
55.23 handled the case for use in training and education activities relating to combating sexual
55.24 exploitation activities of youth; and

55.25 (3) 40 percent of the assessment must be forwarded to the commissioner of ~~public~~
55.26 ~~safety~~ health to be deposited in the safe harbor for youth account in the special revenue
55.27 fund and are appropriated to the commissioner for distribution to crime victims services
55.28 organizations that provide services to sexually exploited youth, as defined in section
55.29 260C.007, subdivision 31.

55.30 (d) A safe harbor for youth account is established as a special account in the state
55.31 treasury.

55.32 Sec. 28. Laws 2015, chapter 71, article 8, section 24, the effective date, is amended to
55.33 read:

56.1 **EFFECTIVE DATE.** This section is effective July 1, 2015, except subdivisions 4
 56.2 and 5, which are effective ~~October 1, 2017~~ January 1, 2018.

56.3 Sec. 29. **EXPANDING ELIGIBILITY FOR DESIGNATION AS A CRITICAL**
 56.4 **ACCESS HOSPITAL.**

56.5 (a) The commissioner of health is encouraged to contact Minnesota's federal elected
 56.6 officials and pursue all necessary changes to the Medicare rural hospital flexibility
 56.7 program established in United States Code, title 42, section 1395i-4 to expand the number
 56.8 of rural hospitals that are eligible for designation as a critical access hospital. In the
 56.9 request for program changes, the commissioner shall seek authority to designate any
 56.10 hospital that applies for designation as a critical access hospital if the hospital:

56.11 (1) is located in a Minnesota county that is a rural area as defined in United States
 56.12 Code, title 42, section 1395ww(d)(2)(D). A hospital is not required to be located 35 miles
 56.13 from another hospital, or 15 miles from another hospital if located in mountainous terrain
 56.14 or in an area with only secondary roads; and

56.15 (2) is licensed under sections 144.50 to 144.56 and is certified to participate in the
 56.16 Medicare program.

56.17 (b) The commissioner shall determine other eligibility criteria for which program
 56.18 changes should be requested, in order to expand eligibility for designation as a critical
 56.19 access hospital to the greatest number of rural hospitals in the state. The commissioner
 56.20 shall report to the chairs and ranking minority members of the legislative committees
 56.21 with jurisdiction over health care finance and policy by January 1, 2017, on the status of
 56.22 the request for program changes.

56.23 Sec. 30. **REPEALER.**

56.24 Minnesota Statutes 2014, section 149A.92, subdivision 11, is repealed the day
 56.25 following final enactment.

56.26 **ARTICLE 5**

56.27 **CHEMICAL AND MENTAL HEALTH**

56.28 Section 1. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 3,
 56.29 is amended to read:

56.30 Subd. 3. ~~Reform projects~~ **Certified community behavioral health clinics.** (a) The
 56.31 commissioner shall establish ~~standards for~~ a state certification of clinics as process for
 56.32 certified community behavioral health clinics, in accordance (CCBHCs) to be eligible for
 56.33 the prospective payment system in paragraph (f). Entities that choose to be CCBHCs must:

57.1 (1) comply with the CCBHC criteria published on or before September 1, 2015, by
57.2 the United States Department of Health and Human Services. Certification standards
57.3 established by the commissioner shall require that:

57.4 ~~(1)~~ (2) employ or contract for clinic staff who have backgrounds in diverse
57.5 disciplines, include including licensed mental health professionals, and staff who are
57.6 culturally and linguistically trained to serve the needs of the clinic's patient population;

57.7 ~~(2)~~ (3) ensure that clinic services are available and accessible to patients of all ages
57.8 and genders and that crisis management services are available 24 hours per day;

57.9 ~~(3)~~ (4) establish fees for clinic services are established for non-medical assistance
57.10 patients using a sliding fee scale and that ensures that services to patients are not denied
57.11 or limited due to a patient's inability to pay for services;

57.12 ~~(4) clinics provide coordination of care across settings and providers to ensure~~
57.13 ~~seamless transitions for patients across the full spectrum of health services, including~~
57.14 ~~acute, chronic, and behavioral needs. Care coordination may be accomplished through~~
57.15 ~~partnerships or formal contracts with federally qualified health centers, inpatient~~
57.16 ~~psychiatric facilities, substance use and detoxification facilities, community-based mental~~
57.17 ~~health providers, and other community services, supports, and providers including~~
57.18 ~~schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health~~
57.19 ~~Services clinics, tribally licensed health care and mental health facilities, urban Indian~~
57.20 ~~health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in~~
57.21 ~~centers, acute care hospitals, and hospital outpatient clinics;~~

57.22 (5) comply with quality assurance reporting requirements and other reporting
57.23 requirements, including any required reporting of encounter data, clinical outcomes data,
57.24 and quality data;

57.25 ~~(5) services provided by clinics include~~ (6) provide crisis mental health services,
57.26 withdrawal management services, emergency crisis intervention services, and stabilization
57.27 services; screening, assessment, and diagnosis services, including risk assessments and
57.28 level of care determinations; patient-centered treatment planning; outpatient mental
57.29 health and substance use services; targeted case management; psychiatric rehabilitation
57.30 services; peer support and counselor services and family support services; and intensive
57.31 community-based mental health services, including mental health services for members of
57.32 the armed forces and veterans; and

57.33 ~~(6) clinics comply with quality assurance reporting requirements and other reporting~~
57.34 ~~requirements, including any required reporting of encounter data, clinical outcomes data,~~
57.35 ~~and quality data.~~

58.1 (7) provide coordination of care across settings and providers to ensure seamless
58.2 transitions for patients across the full spectrum of health services, including acute, chronic,
58.3 and behavioral needs. Care coordination may be accomplished through partnerships
58.4 or formal contracts with:

58.5 (i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally
58.6 qualified health centers, inpatient psychiatric facilities, substance use and detoxification
58.7 facilities, and community-based mental health providers; and

58.8 (ii) other community services, supports, and providers including schools, child
58.9 welfare agencies, juvenile and criminal justice agencies, Indian Health Services clinics,
58.10 tribally licensed health care and mental health facilities, urban Indian health clinics,
58.11 Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute
58.12 care hospitals, and hospital outpatient clinics;

58.13 (8) be certified as mental health clinics under section 245.69, subdivision 2;

58.14 (9) comply with standards relating to integrated treatment for co-occurring mental
58.15 illness and substance use disorders in adults or children under Minnesota Rules, chapter
58.16 9533;

58.17 (10) comply with standards relating to mental health services in Minnesota Rules,
58.18 parts 9505.0370 to 9505.0372;

58.19 (11) be licensed to provide chemical dependency treatment under Minnesota Rules,
58.20 parts 9530.6405 to 9530.6505;

58.21 (12) be certified to provide children's therapeutic services and supports under
58.22 section 256B.0943;

58.23 (13) be certified to provide adult rehabilitative mental health services under section
58.24 256B.0623;

58.25 (14) be enrolled to provide mental health crisis response services under section
58.26 256B.0624;

58.27 (15) be enrolled to provide mental health targeted case management under section
58.28 256B.0625, subdivision 20;

58.29 (16) comply with standards relating to mental health case management in Minnesota
58.30 Rules, parts 9520.0900 to 9520.0926; and

58.31 (17) provide services that comply with the evidence-based practices described in
58.32 paragraph (e).

58.33 (b) If an entity is unable to provide one or more of the services listed in paragraph
58.34 (a), clauses (6) to (17), the commissioner may certify the entity as a CCBHC, if the entity
58.35 has a current contract with another entity that has the required authority to provide that
58.36 service and that meets federal CCBHC criteria as a designated collaborating organization,

59.1 or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a
59.2 referral arrangement. The CCBHC must meet federal requirements regarding the type and
59.3 scope of services to be provided directly by the CCBHC.

59.4 (c) Notwithstanding other law that requires a county contract or other form of county
59.5 approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise
59.6 meets CCBHC requirements may receive the prospective payment under paragraph (f)
59.7 for those services without a county contract or county approval. There is no county
59.8 share when medical assistance pays the CCBHC prospective payment. As part of the
59.9 certification process in paragraph (a), the commissioner shall require a letter of support
59.10 from the CCBHC's host county confirming that the CCBHC and the counties it serves
59.11 have an ongoing relationship to facilitate access and continuity of care, especially for
59.12 individuals who are uninsured or who may go on and off medical assistance.

59.13 (d) In situations where the standards in paragraph (a) or other applicable standards
59.14 conflict or address similar issues in duplicative or incompatible ways, the commissioner
59.15 may grant variances to state requirements as long as the variances do not conflict with
59.16 federal requirements. In situations where standards overlap, the commissioner may decide
59.17 to substitute all or a part of a licensure or certification that is substantially the same as
59.18 another licensure or certification. The commissioner shall consult with stakeholders, as
59.19 described in subdivision 4, before granting variances under this provision.

59.20 (e) The commissioner shall issue a list of required and recommended evidence-based
59.21 practices to be delivered by CCBHCs. The commissioner may update the list to reflect
59.22 advances in outcomes research and medical services for persons living with mental
59.23 illnesses or substance use disorders. The commissioner shall take into consideration the
59.24 adequacy of evidence to support the efficacy of the practice, the quality of workforce
59.25 available, and the current availability of the practice in the state. At least 30 days before
59.26 issuing the initial list and any revisions, the commissioner shall provide stakeholders
59.27 with an opportunity to comment.

59.28 ~~(b)~~ (f) The commissioner shall establish standards and methodologies for a
59.29 prospective payment system for medical assistance payments for mental health services
59.30 delivered by certified community behavioral health clinics, in accordance with guidance
59.31 issued on or before September 1, 2015, by the Centers for Medicare and Medicaid
59.32 Services. During the operation of the demonstration project, payments shall comply with
59.33 federal requirements for a 90 percent an enhanced federal medical assistance percentage.
59.34 The commissioner may include quality bonus payments in the prospective payment
59.35 system based on federal criteria and on a clinic's provision of the evidence-based practices
59.36 in paragraph (e). The prospective payments system does not apply to MinnesotaCare.

60.1 Implementation of the prospective payment system is effective July 1, 2017, or upon
 60.2 federal approval, whichever is later.

60.3 (g) The commissioner shall seek federal approval to continue federal financial
 60.4 participation in payment for CCBHC services after the federal demonstration period
 60.5 ends for clinics that were certified as CCBHCs during the demonstration period and
 60.6 that continue to meet the CCBHC certification standards in paragraph (a). Payment
 60.7 for CCBHC services shall cease effective July 1, 2019, if continued federal financial
 60.8 participation for the payment of CCBHC services cannot be obtained.

60.9 (h) To the extent allowed by federal law, the commissioner may limit the number of
 60.10 certified clinics so that the projected claims for certified clinics will not exceed the funds
 60.11 budgeted for this purpose. The commissioner shall give preference to clinics that:

60.12 (1) are located in both rural and urban areas, with at least one in each, as defined
 60.13 by federal criteria;

60.14 (2) provide a comprehensive range of services and evidence-based practices for all
 60.15 age groups, with services being fully coordinated and integrated; and

60.16 (3) enhance the state's ability to meet the federal priorities to be selected as a
 60.17 CCBHC demonstration state.

60.18 (i) The commissioner shall recertify CCBHCs at least every three years. The
 60.19 commissioner shall establish a process for decertification and shall require corrective
 60.20 action, medical assistance repayment, or decertification of a CCBHC that no longer
 60.21 meets the requirements in this section or that fails to meet the standards provided by the
 60.22 commissioner in the application and certification process.

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

60.24 Sec. 2. Minnesota Statutes 2015 Supplement, section 245.735, subdivision 4, is
 60.25 amended to read:

60.26 Subd. 4. **Public participation.** In developing ~~the projects~~ and implementing
 60.27 certified community behavioral health clinics under subdivision 3, the commissioner shall
 60.28 consult, collaborate, and partner with stakeholders, including but not limited to mental
 60.29 health providers, substance use disorder treatment providers, advocacy organizations,
 60.30 licensed mental health professionals, counties, tribes, hospitals, other health care
 60.31 providers, and Minnesota public health care program enrollees who receive mental health
 60.32 services and their families.

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

61.1 Sec. 3. Minnesota Statutes 2014, section 245.99, subdivision 2, is amended to read:

61.2 Subd. 2. **Rental assistance.** The program shall pay up to 90 days of housing
61.3 assistance for persons with a serious ~~and persistent~~ mental illness who require inpatient or
61.4 residential care for stabilization. The commissioner of human services may extend the
61.5 length of assistance on a case-by-case basis.

61.6 Sec. 4. Minnesota Statutes 2014, section 254B.03, subdivision 4, is amended to read:

61.7 Subd. 4. **Division of costs.** Except for services provided by a county under
61.8 section 254B.09, subdivision 1, or services provided under section 256B.69 or 256D.03,
61.9 subdivision 4, paragraph (b), the county shall, out of local money, pay the state for ~~22.95~~
61.10 15 percent of the cost of chemical dependency services, including those services provided
61.11 to persons eligible for medical assistance under chapter 256B and general assistance
61.12 medical care under chapter 256D. Counties may use the indigent hospitalization levy for
61.13 treatment and hospital payments made under this section. ~~22.95~~ Fifteen percent of any
61.14 state collections from private or third-party pay, less 15 percent for the cost of payment
61.15 and collections, must be distributed to the county that paid for a portion of the treatment
61.16 under this section.

61.17 **EFFECTIVE DATE.** This section is effective July 1, 2016, and expires June 30,
61.18 2017.

61.19 Sec. 5. Minnesota Statutes 2014, section 254B.04, subdivision 2a, is amended to read:

61.20 Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding
61.21 provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's
61.22 discretion in making placements to residential treatment settings, a person eligible for
61.23 services under this section must score at level 4 on assessment dimensions related to
61.24 relapse, continued use, or recovery environment in order to be assigned to services with a
61.25 room and board component reimbursed under this section. Whether a treatment facility
61.26 has been designated an institution for mental diseases under United States Code, title 42,
61.27 section 1396d, shall not be a factor in making placements.

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

61.29 Sec. 6. Minnesota Statutes 2014, section 254B.06, subdivision 2, is amended to read:

61.30 Subd. 2. **Allocation of collections.** The commissioner shall allocate all federal
61.31 financial participation collections to a special revenue account. The commissioner shall

62.1 allocate ~~77.05~~ 85 percent of patient payments and third-party payments to the special
62.2 revenue account and ~~22.95~~ 15 percent to the county financially responsible for the patient.

62.3 **EFFECTIVE DATE.** This section is effective July 1, 2016, and expires June 30,
62.4 2017.

62.5 Sec. 7. Minnesota Statutes 2014, section 254B.06, is amended by adding a subdivision
62.6 to read:

62.7 Subd. 4. **Reimbursement for institutions for mental diseases.** The commissioner
62.8 shall not deny reimbursement to a program designated as an institution for mental diseases
62.9 under United States Code, title 42, section 1396d, due to a reduction in federal financial
62.10 participation and the addition of new residential beds.

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

62.12 Sec. 8. **[254B.15] PILOT PROJECTS; TREATMENT FOR PREGNANT AND**
62.13 **POSTPARTUM WOMEN WITH SUBSTANCE USE DISORDER.**

62.14 Subdivision 1. **Pilot projects established.** (a) Within the limits of federal funds
62.15 available specifically for this purpose, the commissioner of human services shall establish
62.16 pilot projects to provide substance use disorder treatment and services to pregnant and
62.17 postpartum women with a primary diagnosis of substance use disorder, including opioid
62.18 use disorder. Pilot projects funded under this section must:

62.19 (1) promote flexible uses of funds to provide treatment and services to pregnant and
62.20 postpartum women with substance use disorders;

62.21 (2) fund family-based treatment and services for pregnant and postpartum women
62.22 with substance use disorders;

62.23 (3) identify gaps in services along the continuum of care that are provided to
62.24 pregnant and postpartum women with substance use disorders; and

62.25 (4) encourage new approaches to service delivery and service delivery models.

62.26 (b) A pilot project funded under this section must provide at least a portion of its
62.27 treatment and services to women who receive services on an outpatient basis.

62.28 Subd. 2. **Federal funds.** The commissioner shall apply for any available grant funds
62.29 from the federal Center for Substance Abuse Treatment for these pilot projects.

62.30 Sec. 9. Minnesota Statutes 2014, section 256B.0621, subdivision 10, is amended to read:

63.1 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted
63.2 case management under this subdivision. Case managers may bill according to the
63.3 following criteria:

63.4 (1) for relocation targeted case management, case managers may bill for direct case
63.5 management activities, including face-to-face ~~and~~, telephone contacts, and interactive
63.6 video contact in accordance with section 256B.0924, subdivision 4a, in the lesser of:

63.7 (i) 180 days preceding an eligible recipient's discharge from an institution; or

63.8 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

63.9 (2) for home care targeted case management, case managers may bill for direct case
63.10 management activities, including face-to-face and telephone contacts; and

63.11 (3) billings for targeted case management services under this subdivision shall not
63.12 duplicate payments made under other program authorities for the same purpose.

63.13 Sec. 10. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 20,
63.14 is amended to read:

63.15 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule
63.16 of the state agency, medical assistance covers case management services to persons with
63.17 serious and persistent mental illness and children with severe emotional disturbance.
63.18 Services provided under this section must meet the relevant standards in sections 245.461
63.19 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota
63.20 Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

63.21 (b) Entities meeting program standards set out in rules governing family community
63.22 support services as defined in section 245.4871, subdivision 17, are eligible for medical
63.23 assistance reimbursement for case management services for children with severe
63.24 emotional disturbance when these services meet the program standards in Minnesota
63.25 Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

63.26 (c) Medical assistance and MinnesotaCare payment for mental health case
63.27 management shall be made on a monthly basis. In order to receive payment for an eligible
63.28 child, the provider must document at least a face-to-face contact with the child, the child's
63.29 parents, or the child's legal representative. To receive payment for an eligible adult, the
63.30 provider must document:

63.31 (1) at least a face-to-face contact with the adult or the adult's legal representative or a
63.32 contact by interactive video that meets the requirements of subdivision 20b; or

63.33 (2) at least a telephone contact with the adult or the adult's legal representative
63.34 and document a face-to-face contact or a contact by interactive video that meets the

64.1 requirements of subdivision 20b with the adult or the adult's legal representative within
64.2 the preceding two months.

64.3 (d) Payment for mental health case management provided by county or state staff
64.4 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
64.5 paragraph (b), with separate rates calculated for child welfare and mental health, and
64.6 within mental health, separate rates for children and adults.

64.7 (e) Payment for mental health case management provided by Indian health services
64.8 or by agencies operated by Indian tribes may be made according to this section or other
64.9 relevant federally approved rate setting methodology.

64.10 (f) Payment for mental health case management provided by vendors who contract
64.11 with a county or Indian tribe shall be based on a monthly rate negotiated by the host county
64.12 or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
64.13 service to other payers. If the service is provided by a team of contracted vendors, the
64.14 county or tribe may negotiate a team rate with a vendor who is a member of the team. The
64.15 team shall determine how to distribute the rate among its members. No reimbursement
64.16 received by contracted vendors shall be returned to the county or tribe, except to reimburse
64.17 the county or tribe for advance funding provided by the county or tribe to the vendor.

64.18 (g) If the service is provided by a team which includes contracted vendors, tribal
64.19 staff, and county or state staff, the costs for county or state staff participation in the team
64.20 shall be included in the rate for county-provided services. In this case, the contracted
64.21 vendor, the tribal agency, and the county may each receive separate payment for services
64.22 provided by each entity in the same month. In order to prevent duplication of services,
64.23 each entity must document, in the recipient's file, the need for team case management and
64.24 a description of the roles of the team members.

64.25 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs
64.26 for mental health case management shall be provided by the recipient's county of
64.27 responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal
64.28 funds or funds used to match other federal funds. If the service is provided by a tribal
64.29 agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this
64.30 service is paid by the state without a federal share through fee-for-service, 50 percent of
64.31 the cost shall be provided by the recipient's county of responsibility.

64.32 (i) Notwithstanding any administrative rule to the contrary, prepaid medical
64.33 assistance, general assistance medical care, and MinnesotaCare include mental health case
64.34 management. When the service is provided through prepaid capitation, the nonfederal
64.35 share is paid by the state and the county pays no share.

65.1 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a
 65.2 provider that does not meet the reporting or other requirements of this section. The county
 65.3 of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal
 65.4 agency, is responsible for any federal disallowances. The county or tribe may share this
 65.5 responsibility with its contracted vendors.

65.6 (k) The commissioner shall set aside a portion of the federal funds earned for county
 65.7 expenditures under this section to repay the special revenue maximization account under
 65.8 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

65.9 (1) the costs of developing and implementing this section; and

65.10 (2) programming the information systems.

65.11 (l) Payments to counties and tribal agencies for case management expenditures
 65.12 under this section shall only be made from federal earnings from services provided
 65.13 under this section. When this service is paid by the state without a federal share through
 65.14 fee-for-service, 50 percent of the cost shall be provided by the state. Payments to
 65.15 county-contracted vendors shall include the federal earnings, the state share, and the
 65.16 county share.

65.17 (m) Case management services under this subdivision do not include therapy,
 65.18 treatment, legal, or outreach services.

65.19 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or
 65.20 hospital, and the recipient's institutional care is paid by medical assistance, payment for
 65.21 case management services under this subdivision is limited to the lesser of:

65.22 (1) the last 180 days of the recipient's residency in that facility and may not exceed
 65.23 more than six months in a calendar year; or

65.24 (2) the limits and conditions which apply to federal Medicaid funding for this service.

65.25 (o) Payment for case management services under this subdivision shall not duplicate
 65.26 payments made under other program authorities for the same purpose.

65.27 (p) If the recipient is receiving care in a hospital, nursing facility, or a residential
 65.28 setting licensed under chapter 245A or 245D that is staffed 24 hours per day, seven
 65.29 days per week, mental health targeted case management services must actively support
 65.30 identification of community alternatives and discharge planning for the recipient.

65.31 Sec. 11. Minnesota Statutes 2014, section 256B.0625, is amended by adding a
 65.32 subdivision to read:

65.33 Subd. 20b. **Mental health targeted case management through interactive video.**

65.34 (a) Subject to federal approval, contact made for targeted case management by interactive
 65.35 video shall be eligible for payment under section 256B.0924, subdivision 6, if:

- 66.1 (1) the person receiving targeted case management services is residing in:
66.2 (i) a hospital;
66.3 (ii) a nursing facility; or
66.4 (iii) a residential setting licensed under chapter 245A or 245D, or a boarding and
66.5 lodging establishment or a lodging establishment that provides supportive services or
66.6 health supervision services according to section 157.17, that is staffed 24 hours per day,
66.7 seven days per week;
- 66.8 (2) interactive video is in the best interests of the person and is deemed appropriate
66.9 by the person receiving targeted case management or the person's legal guardian, the case
66.10 management provider, and the provider operating the setting where the person is residing;
- 66.11 (3) the use of interactive video is approved as part of the person's written personal
66.12 service or case plan taking into consideration the person's vulnerability and active personal
66.13 relationships; and
- 66.14 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
66.15 required face-to-face contacts.
- 66.16 (b) The person receiving targeted case management or the person's legal guardian
66.17 has the right to choose and consent to the use of interactive video under this subdivision
66.18 and has the right to refuse the use of interactive video at any time.
- 66.19 (c) The commissioner shall establish criteria that a targeted case management
66.20 provider must attest to in order to demonstrate the safety or efficacy of delivering the service
66.21 via interactive video. The attestation may include that the case management provider has:
- 66.22 (1) written policies and procedures specific to interactive video services that are
66.23 regularly reviewed and updated;
- 66.24 (2) policies and procedures that adequately address client safety before, during, and
66.25 after the interactive video services are rendered;
- 66.26 (3) established protocols addressing how and when to discontinue interactive video
66.27 services; and
- 66.28 (4) established a quality assurance process related to interactive video services.
- 66.29 (d) As a condition of payment, the targeted case management provider must
66.30 document the following for each occurrence of targeted case management provided by
66.31 interactive video:
- 66.32 (1) the time the service began and the time the service ended, including an a.m. and
66.33 p.m. designation;
- 66.34 (2) the basis for determining that interactive video is an appropriate and effective
66.35 means for delivering the service to the person receiving case management services;

- 67.1 (3) the mode of transmission of the interactive video services and records evidencing
67.2 that a particular mode of transmission was utilized;
67.3 (4) the location of the originating site and the distant site; and
67.4 (5) compliance with the criteria attested to by the targeted case management provider
67.5 as provided in paragraph (c).

67.6 Sec. 12. Minnesota Statutes 2014, section 256B.0924, is amended by adding a
67.7 subdivision to read:

67.8 Subd. 4a. Targeted case management through interactive video. (a) Subject to
67.9 federal approval, contact made for targeted case management by interactive video shall be
67.10 eligible for payment under subdivision 6 if:

67.11 (1) the person receiving targeted case management services is residing in:

67.12 (i) a hospital;

67.13 (ii) a nursing facility;

67.14 (iii) a residential setting licensed under chapter 245A or 245D, or a boarding and
67.15 lodging establishment or a lodging establishment that provides supportive services or
67.16 health supervision services according to section 157.17, that is staffed 24 hours per day,
67.17 seven days per week;

67.18 (2) interactive video is in the best interests of the person and is deemed appropriate
67.19 by the person receiving targeted case management or the person's legal guardian, the case
67.20 management provider, and the provider operating the setting where the person is residing;

67.21 (3) the use of interactive video is approved as part of the person's written personal
67.22 service or case plan; and

67.23 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
67.24 required face-to-face contacts.

67.25 (b) The person receiving targeted case management or the person's legal guardian
67.26 has the right to choose and consent to the use of interactive video under this subdivision
67.27 and has the right to refuse the use of interactive video at any time.

67.28 (c) The commissioner shall establish criteria that a targeted case management
67.29 provider must attest to in order to demonstrate the safety or efficacy of delivering the service
67.30 via interactive video. The attestation may include that the case management provider has:

67.31 (1) written policies and procedures specific to interactive video services that are
67.32 regularly reviewed and updated;

67.33 (2) policies and procedures that adequately address client safety before, during, and
67.34 after the interactive video services are rendered;

68.1 (3) established protocols addressing how and when to discontinue interactive video
68.2 services; and

68.3 (4) established a quality assurance process related to interactive video services.

68.4 (d) As a condition of payment, the targeted case management provider must
68.5 document the following for each occurrence of targeted case management provided by
68.6 interactive video:

68.7 (1) the time the service began and the time the service ended, including an a.m. and
68.8 p.m. designation;

68.9 (2) the basis for determining that interactive video is an appropriate and effective
68.10 means for delivering the service to the person receiving case management services;

68.11 (3) the mode of transmission of the interactive video services and records evidencing
68.12 that a particular mode of transmission was utilized;

68.13 (4) the location of the originating site and the distant site; and

68.14 (5) compliance with the criteria attested to by the targeted case management provider
68.15 as provided in paragraph (c).

68.16 Sec. 13. **COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL.**

68.17 The commissioner of human services shall seek federal approval that is necessary
68.18 to implement Minnesota Statutes, sections 256B.0621, subdivision 10, and 256B.0625,
68.19 subdivision 20, for interactive video contact.

68.20 Sec. 14. **RURAL DEMONSTRATION PROJECT.**

68.21 (a) Children's mental health collaboratives under Minnesota Statutes, section
68.22 245.493, are eligible to apply for grant funding under this section. The commissioner shall
68.23 solicit proposals and select the proposal that best meets the requirements under paragraph
68.24 (c). Only one demonstration project may be funded under this section.

68.25 (b) The demonstration project must:

68.26 (1) support youth served to achieve, within their potential, their personal goals
68.27 in employment, education, living situation, personal effectiveness, and community life
68.28 functioning;

68.29 (2) build on and streamline transition services by identifying rural youth ages 15 to
68.30 25 currently in the mental health system or with emerging mental health conditions;

68.31 (3) provide individualized motivational coaching;

68.32 (4) build needed social supports;

68.33 (5) demonstrate how services can be enhanced for youth to successfully navigate the
68.34 complexities associated with their unique needs;

69.1 (6) utilize all available funding streams;
 69.2 (7) evaluate the effectiveness of the project; and
 69.3 (8) compare differences in outcomes and costs to youth without previous access
 69.4 to this project.

69.5 (c) The commissioner shall report to the chairs and ranking minority members of
 69.6 the house of representatives and senate committees with jurisdiction over mental health
 69.7 issues on the status and outcomes of the demonstration project by January 15, 2019. The
 69.8 children's mental health collaboratives administering the demonstration project shall
 69.9 collect and report outcome data, per guidelines approved by the commissioner, to support
 69.10 the development of this report.

69.11 **ARTICLE 6**

69.12 **CHILDREN AND FAMILIES**

69.13 Section 1. Minnesota Statutes 2014, section 119B.13, subdivision 1, is amended to read:

69.14 Subdivision 1. **Subsidy restrictions.** (a) Beginning February 3, 2014, the maximum
 69.15 rate paid for child care assistance in any county or county price cluster under the child
 69.16 care fund shall be the greater of the 25th percentile of the 2011 child care provider rate
 69.17 survey or the maximum rate effective November 28, 2011. For a child care provider
 69.18 located inside the boundaries of a city located in two or more counties, the maximum rate
 69.19 paid for child care assistance shall be equal to the maximum rate paid in the county with
 69.20 the highest maximum reimbursement rates or the provider's charge, whichever is less. The
 69.21 commissioner may: (1) assign a county with no reported provider prices to a similar price
 69.22 cluster; and (2) consider county level access when determining final price clusters.

69.23 (b) A rate which includes a special needs rate paid under subdivision 3 may be in
 69.24 excess of the maximum rate allowed under this subdivision.

69.25 (c) The department shall monitor the effect of this paragraph on provider rates. The
 69.26 county shall pay the provider's full charges for every child in care up to the maximum
 69.27 established. The commissioner shall determine the maximum rate for each type of care
 69.28 on an hourly, full-day, and weekly basis, including special needs and disability care. The
 69.29 maximum payment to a provider for one day of care must not exceed the daily rate. The
 69.30 maximum payment to a provider for one week of care must not exceed the weekly rate.

69.31 (d) Child care providers receiving reimbursement under this chapter must not be
 69.32 paid activity fees or an additional amount above the maximum rates for care provided
 69.33 during nonstandard hours for families receiving assistance.

70.1 (e) When the provider charge is greater than the maximum provider rate allowed,
70.2 the parent is responsible for payment of the difference in the rates in addition to any
70.3 family co-payment fee.

70.4 (f) All maximum provider rates changes shall be implemented on the Monday
70.5 following the effective date of the maximum provider rate.

70.6 (g) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum
70.7 registration fees in effect on January 1, 2013, shall remain in effect.

70.8 **EFFECTIVE DATE.** This section is effective September 11, 2017.

70.9 Sec. 2. **[245A.043] ELECTRONIC APPLICATION; INFORMATION.**

70.10 (a) The commissioner, in consultation with child care providers, shall conduct a
70.11 feasibility study regarding the development of a single, easily accessible Web site that
70.12 complies with the requirements contained in the federal reauthorization of the federal
70.13 Child Care Development Fund. In conducting the study, the commissioner shall review
70.14 current child care licensing processes and regulations in order to determine methods by
70.15 which the commissioner can streamline processes for current and prospective child care
70.16 providers including but not limited to applications for licensure, license renewals, and
70.17 provider record keeping. As part of this review, the commissioner must evaluate the
70.18 feasibility of developing an online system that would allow child care providers and
70.19 prospective child care providers to:

70.20 (1) access a guide on how to start a child care business;

70.21 (2) access all applicable statutes, administrative rules, and agency policies and
70.22 procedures, including training requirements;

70.23 (3) access up-to-date contact information for state and county agency licensing staff;

70.24 (4) access information on the availability of grant programs and other resources
70.25 for providers;

70.26 (5) use an online reimbursement tool for payment under the child care assistance
70.27 programs; and

70.28 (6) submit a single electronic application and license renewal, including all
70.29 supporting documentation required by the commissioner, information related to child
70.30 care assistance program registration, and application for rating in the quality rating and
70.31 improvement system.

70.32 (b) The commissioner shall submit the feasibility study to the chairs and ranking
70.33 minority members of the house of representatives and senate committees with jurisdiction
70.34 over child care by September 30, 2016.

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

71.2 Sec. 3. **[245A.055] NOTIFICATION TO PROVIDER.**

71.3 (a) When the county employee responsible for family child care and group family
71.4 child care licensing conducts a licensing inspection or conducts a home visit, the employee
71.5 must provide, prior to departure from the residence or facility, a written notification to
71.6 the licensee of any potential licensing violations noted. The notification must include
71.7 the condition that constitutes the violation, the action that must be taken to correct the
71.8 condition, and the time allowed to correct the violation.

71.9 (b) Providing this notification to the licensee does not relieve the county employee
71.10 from notifying the commissioner of the violation as required by statute and administrative
71.11 rule.

71.12 Sec. 4. **[245A.23] POSITIVE SUPPORT STRATEGIES.**

71.13 (a) The commissioner of human services, in conjunction with licensed programs that
71.14 provide group family day care and family day care under Minnesota Rules, chapter 9502,
71.15 and child care centers licensed under Minnesota Rules, chapter 9503, must review and
71.16 evaluate the applicability of Minnesota Rules, chapter 9544, the positive support strategies
71.17 and restrictive interventions rules, to child care programs. The commissioner must
71.18 consider the undue hardship, including increased cost and reduction in child care services,
71.19 experienced by child care providers and child care centers as a result of the application
71.20 of Minnesota Rules, chapter 9544. The commissioner must determine which rules must
71.21 apply to each type of program, to what extent each rule must apply, and consider granting
71.22 variances to the requirements to programs that submit a request for a variance. The
71.23 commissioner must complete this review and evaluation process of the applicability of
71.24 Minnesota Rules, chapter 9544, to child care programs no later than December 31, 2016.
71.25 The commissioner must submit a written plan to modify application of rules for child care
71.26 programs to the house of representatives and senate committees with jurisdiction over
71.27 child care no later than January 15, 2017.

71.28 (b) Until the commissioner has completed the review and evaluation process and
71.29 submitted a written plan to the legislature required under paragraph (a), programs licensed
71.30 as family day care and group family day care facilities under Minnesota Rules, chapter
71.31 9502, and programs licensed as child care centers under Minnesota Rules, chapter 9503,
71.32 are exempt from the following rules:

71.33 (1) Minnesota Rules, part 9544.0040, functional behavior assessment, unless the
71.34 child has a case manager under section 256B.092, subdivision 1a, paragraph (e); and

72.1 (2) Minnesota Rules, part 9544.0090, staff qualifications and training.

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

72.3 Sec. 5. **[245A.55] TRAINING FOR COUNTY LICENSING STAFF ON FAMILY**
72.4 **CHILD CARE AND GROUP FAMILY CHILD CARE REQUIREMENTS;**
72.5 **SUPERVISION.**

72.6 (a) Within the first two months of employment, county staff who license and inspect
72.7 family child care and group family child care programs must complete at least eight hours
72.8 of training on state statutes, administrative rules, and department policies related to the
72.9 licensing and regulation of family child care and group family child care programs. The
72.10 department must develop the training curriculum to ensure that all county staff who perform
72.11 licensing and inspection functions receive uniform training. This training must include:

72.12 (1) explicit instructions that county staff who license and perform inspections
72.13 must apply only state statutes, administrative rules, and Department of Human Services
72.14 policies in the performance of their duties. Training must reinforce that county staff are
72.15 prohibited from imposing standards or requirements that are not imposed by statute, rule,
72.16 or approved state policy;

72.17 (2) the rights of license holders, including their grievance and appeal rights. This
72.18 training must include information on the responsibility of the county staff to inform license
72.19 holders of their rights, including grievance and appeal rights; and

72.20 (3) the procedure for county staff to seek clarification from the Department of
72.21 Human Services prior to issuing a correction order or other notice of violation to a license
72.22 holder if there is a dispute between the license holder and the county licensor regarding
72.23 the applicability of a statute or rule to the alleged violation.

72.24 (b) To ensure consistency among all licensing staff, the commissioner must develop
72.25 a procedure by which the department will implement increased training and oversight of
72.26 county staff who perform licensing functions related to family child care licensing. This
72.27 procedure must ensure that the commissioner conducts at least biennial reviews of county
72.28 licensing performance.

72.29 (c) Each calendar year, county agency staff who license and regulate family child
72.30 care providers and group family child care providers and their supervisors must receive
72.31 notice from the commissioner on new laws enacted or adopted in the previous 12-month
72.32 period relating to family child care providers and group family child care providers. The
72.33 commissioner shall provide the notices each year to include information on new laws and
72.34 disseminate the notices to county agencies.

73.1 Sec. 6. Minnesota Statutes 2014, section 256D.051, subdivision 6b, is amended to read:

73.2 Subd. 6b. **Federal reimbursement.** (a) Federal financial participation from
73.3 the United States Department of Agriculture for food stamp employment and training
73.4 expenditures that are eligible for reimbursement through the food stamp employment and
73.5 training program are dedicated funds and are annually appropriated to the commissioner
73.6 of human services for the operation of the food stamp employment and training program.

73.7 (b) The appropriation must be used for skill attainment through employment,
73.8 training, and support services for food stamp participants. By February 15, 2017, the
73.9 commissioner shall report to the chairs and ranking minority members of the legislative
73.10 committees having jurisdiction over the food stamp program on the progress of securing
73.11 additional federal reimbursement dollars under this program.

73.12 (c) Federal financial participation for the nonstate portion of food stamp employment
73.13 and training costs must be paid to the county agency or service provider that incurred
73.14 the costs.

73.15 Sec. 7. Minnesota Statutes 2014, section 518.175, subdivision 5, is amended to read:

73.16 Subd. 5. **Modification of parenting plan or order for parenting time.** (a) If
73.17 a parenting plan or an order granting parenting time cannot be used to determine the
73.18 number of overnights or overnight equivalents the child has with each parent, the court
73.19 shall modify the parenting plan or order granting parenting time so that the number of
73.20 overnights or overnight equivalents the child has with each parent can be determined. For
73.21 purposes of this section, "overnight equivalents" has the meaning provided in section
73.22 518A.36, subdivision 1.

73.23 (b) If modification would serve the best interests of the child, the court shall modify
73.24 the decision-making provisions of a parenting plan or an order granting or denying
73.25 parenting time, if the modification would not change the child's primary residence.
73.26 Consideration of a child's best interest includes a child's changing developmental needs.

73.27 ~~(b)~~ (c) Except as provided in section 631.52, the court may not restrict parenting
73.28 time unless it finds that:

73.29 (1) parenting time is likely to endanger the child's physical or emotional health or
73.30 impair the child's emotional development; or

73.31 (2) the parent has chronically and unreasonably failed to comply with court-ordered
73.32 parenting time.

73.33 A modification of parenting time which increases a parent's percentage of parenting time
73.34 to an amount that is between 45.1 to 54.9 percent parenting time is not a restriction of
73.35 the other parent's parenting time.

74.1 (e) (d) If a parent makes specific allegations that parenting time by the other
74.2 parent places the parent or child in danger of harm, the court shall hold a hearing at
74.3 the earliest possible time to determine the need to modify the order granting parenting
74.4 time. Consistent with subdivision 1a, the court may require a third party, including the
74.5 local social services agency, to supervise the parenting time or may restrict a parent's
74.6 parenting time if necessary to protect the other parent or child from harm. If there is an
74.7 existing order for protection governing the parties, the court shall consider the use of an
74.8 independent, neutral exchange location for parenting time.

74.9 **EFFECTIVE DATE.** This section is effective August 1, 2018.

74.10 Sec. 8. Minnesota Statutes 2015 Supplement, section 518A.26, subdivision 14, is
74.11 amended to read:

74.12 Subd. 14. **Obligor.** "Obligor" means a person obligated to pay maintenance or
74.13 support. For purposes of ordering medical support under section 518A.41, a parent who
74.14 has primary physical custody of a child may be an obligor subject to a payment agreement
74.15 under section 518A.69. If a parent has more than 55 percent court-ordered parenting time,
74.16 there is a rebuttable presumption that the parent shall have a zero-dollar basic support
74.17 obligation. A party seeking to overcome this presumption must show, and the court must
74.18 consider, the following:

74.19 (1) a significant income disparity, which may include potential income determined
74.20 under section 518A.32;

74.21 (2) the benefit and detriment to the child and the ability of each parent to meet
74.22 the needs of the child; and

74.23 (3) whether the application of the presumption would have an unjust or inappropriate
74.24 result.

74.25 The presumption of a zero-dollar basic support obligation does not eliminate that parent's
74.26 obligation to pay child support arrears pursuant to section 518A.60.

74.27 **EFFECTIVE DATE.** This section is effective August 1, 2018.

74.28 Sec. 9. Minnesota Statutes 2014, section 518A.34, is amended to read:

74.29 **518A.34 COMPUTATION OF CHILD SUPPORT OBLIGATIONS.**

74.30 (a) To determine the presumptive child support obligation of a parent, the court shall
74.31 follow the procedure set forth in this section.

74.32 (b) To determine the obligor's basic support obligation, the court shall:

74.33 (1) determine the gross income of each parent under section 518A.29;

75.1 (2) calculate the parental income for determining child support (PICS) of each
75.2 parent, by subtracting from the gross income the credit, if any, for each parent's nonjoint
75.3 children under section 518A.33;

75.4 (3) determine the percentage contribution of each parent to the combined PICS by
75.5 dividing the combined PICS into each parent's PICS;

75.6 (4) determine the combined basic support obligation by application of the guidelines
75.7 in section 518A.35;

75.8 (5) determine ~~the obligor's~~ each parent's share of the combined basic support
75.9 obligation by multiplying the percentage figure from clause (3) by the combined basic
75.10 support obligation in clause (4); and

75.11 (6) ~~determine the parenting expense adjustment, if any, as apply the parenting~~
75.12 ~~expense adjustment formula provided in section 518A.36, and adjust the obligor's basic~~
75.13 ~~support obligation accordingly to determine the obligor's basic support obligation. If the~~
75.14 ~~parenting time of the parties is presumed equal, section 518A.36, subdivision 3, applies~~
75.15 ~~to the calculation of the basic support obligation and a determination of which parent~~
75.16 ~~is the obligor.~~

75.17 (c) If the parents have split custody of the joint children, child support shall be
75.18 calculated for each joint child as follows:

75.19 (1) the court shall determine each parent's basic support obligation under paragraph
75.20 (b) and shall include the amount of each parent's obligation in the court order. If the basic
75.21 support calculation results in each parent owing support to the other, the court shall offset
75.22 the higher basic support obligation with the lower basic support obligation to determine
75.23 the amount to be paid by the parent with the higher obligation to the parent with the
75.24 lower obligation. For the purpose of the cost-of-living adjustment required under section
75.25 518A.75, the adjustment must be based on each parent's basic support obligation prior to
75.26 offset. For the purposes of this paragraph, "split custody" means that there are two or more
75.27 joint children and each parent has at least one joint child more than 50 percent of the time;

75.28 (2) if each parent pays all child care expenses for at least one joint child, the court
75.29 shall calculate child care support for each joint child as provided in section 518A.40. The
75.30 court shall determine each parent's child care support obligation and include the amount of
75.31 each parent's obligation in the court order. If the child care support calculation results in
75.32 each parent owing support to the other, the court shall offset the higher child care support
75.33 obligation with the lower child care support obligation to determine the amount to be paid
75.34 by the parent with the higher obligation to the parent with the lower obligation; and

75.35 (3) if each parent pays all medical or dental insurance expenses for at least one
75.36 joint child, medical support shall be calculated for each joint child as provided in section

76.1 518A.41. The court shall determine each parent's medical support obligation and include
 76.2 the amount of each parent's obligation in the court order. If the medical support calculation
 76.3 results in each parent owing support to the other, the court shall offset the higher medical
 76.4 support obligation with the lower medical support obligation to determine the amount to
 76.5 be paid by the parent with the higher obligation to the parent with the lower obligation.
 76.6 Unreimbursed and uninsured medical expenses are not included in the presumptive amount
 76.7 of support owed by a parent and are calculated and collected as provided in section 518A.41.

76.8 (d) The court shall determine the child care support obligation for the obligor
 76.9 as provided in section 518A.40.

76.10 ~~(d)~~ (e) The court shall determine the medical support obligation for each parent as
 76.11 provided in section 518A.41. Unreimbursed and uninsured medical expenses are not
 76.12 included in the presumptive amount of support owed by a parent and are calculated and
 76.13 collected as described in section 518A.41.

76.14 ~~(e)~~ (f) The court shall determine each parent's total child support obligation by
 76.15 adding together each parent's basic support, child care support, and health care coverage
 76.16 obligations as provided in this section.

76.17 ~~(f)~~ (g) If Social Security benefits or veterans' benefits are received by one parent as a
 76.18 representative payee for a joint child based on the other parent's eligibility, the court shall
 76.19 subtract the amount of benefits from the other parent's net child support obligation, if any.

76.20 ~~(g)~~ (h) The final child support order shall separately designate the amount owed for
 76.21 basic support, child care support, and medical support. If applicable, the court shall use
 76.22 the self-support adjustment and minimum support adjustment under section 518A.42 to
 76.23 determine the obligor's child support obligation.

76.24 **EFFECTIVE DATE.** This section is effective August 1, 2018.

76.25 Sec. 10. Minnesota Statutes 2014, section 518A.36, is amended to read:

76.26 **518A.36 PARENTING EXPENSE ADJUSTMENT.**

76.27 Subdivision 1. **General.** (a) The parenting expense adjustment under this section
 76.28 reflects the presumption that while exercising parenting time, a parent is responsible
 76.29 for and incurs costs of caring for the child, including, but not limited to, food, clothing,
 76.30 transportation, recreation, and household expenses. Every child support order shall specify
 76.31 the percentage of parenting time granted to or presumed for each parent. For purposes
 76.32 of this section, the percentage of parenting time means the percentage of time a child is
 76.33 scheduled to spend with the parent during a calendar year according to a court order
 76.34 averaged over a two-year period. Parenting time includes time with the child whether it is

77.1 designated as visitation, physical custody, or parenting time. The percentage of parenting
 77.2 time may be determined by calculating the number of overnights or overnight equivalents
 77.3 that a child parent spends with a parent, or child pursuant to a court order. For purposes of
 77.4 this section, overnight equivalents are calculated by using a method other than overnights
 77.5 if the parent has significant time periods on separate days where the child is in the parent's
 77.6 physical custody and under the direct care of the parent but does not stay overnight. The
 77.7 court may consider the age of the child in determining whether a child is with a parent
 77.8 for a significant period of time.

77.9 (b) If there is not a court order awarding parenting time, the court shall determine
 77.10 the child support award without consideration of the parenting expense adjustment. If a
 77.11 parenting time order is subsequently issued or is issued in the same proceeding, then the
 77.12 child support order shall include application of the parenting expense adjustment.

77.13 **Subd. 2. Calculation of parenting expense adjustment.** ~~The obligor is entitled to~~
 77.14 ~~a parenting expense adjustment calculated as provided in this subdivision. The court shall:~~

77.15 ~~(1) find the adjustment percentage corresponding to the percentage of parenting~~
 77.16 ~~time allowed to the obligor below:~~

	Percentage Range of Parenting Time	Adjustment Percentage
77.17		
77.18		
77.19	(i) less than 10 percent	no adjustment
77.20	(ii) 10 percent to 45 percent	12 percent
77.21	(iii) 45.1 percent to 50 percent	presume parenting time is equal

77.22 ~~(2) multiply the adjustment percentage by the obligor's basic child support obligation~~
 77.23 ~~to arrive at the parenting expense adjustment; and~~

77.24 ~~(3) subtract the parenting expense adjustment from the obligor's basic child support~~
 77.25 ~~obligation. The result is the obligor's basic support obligation after parenting expense~~
 77.26 ~~adjustment.~~

77.27 (a) For the purposes of this section, the following terms have the meanings given:

77.28 (1) "parent A" means the parent with whom the child or children will spend the least
 77.29 number of overnights under the court order; and

77.30 (2) "parent B" means the parent with whom the child or children will spend the
 77.31 greatest number of overnights under the court order.

77.32 (b) The court shall apply the following formula to determine which parent is the
 77.33 obligor and calculate the basic support obligation:

77.34 (1) raise to the power of three the approximate number of annual overnights the child
 77.35 or children will likely spend with parent A;

77.36 (2) raise to the power of three the approximate number of annual overnights the child
 77.37 or children will likely spend with parent B;

78.1 (3) multiply the result of clause (1) times parent B's share of the combined basic
 78.2 support obligation as determined in section 518A.34, paragraph (b), clause (5);

78.3 (4) multiply the result of clause (2) times parent A's share of the combined basic
 78.4 support obligation as determined in section 518A.34, paragraph (b), clause (5);

78.5 (5) subtract the result of clause (4) from the result of clause (3); and

78.6 (6) divide the result of clause (5) by the sum of clauses (1) and (2).

78.7 (c) If the result is a negative number, parent A is the obligor, the negative number
 78.8 becomes its positive equivalent, and the result is the basic support obligation. If the result
 78.9 is a positive number, parent B is the obligor and the result is the basic support obligation.

78.10 **Subd. 3. Calculation of basic support when parenting time presumed is equal.**

78.11 **(a)** If the parenting time is equal and the parental incomes for determining child support of
 78.12 the parents also are equal, no basic support shall be paid unless the court determines that
 78.13 the expenses for the child are not equally shared.

78.14 ~~(b) If the parenting time is equal but the parents' parental incomes for determining~~
 78.15 ~~child support are not equal, the parent having the greater parental income for determining~~
 78.16 ~~child support shall be obligated for basic child support, calculated as follows:~~

78.17 ~~(1) multiply the combined basic support calculated under section 518A.34 by 0.75;~~

78.18 ~~(2) prorate the amount under clause (1) between the parents based on each parent's~~
 78.19 ~~proportionate share of the combined PICS; and~~

78.20 ~~(3) subtract the lower amount from the higher amount.~~

78.21 ~~The resulting figure is the obligation after parenting expense adjustment for the~~
 78.22 ~~parent with the greater parental income for determining child support.~~

78.23 **EFFECTIVE DATE.** This section is effective August 1, 2018.

78.24 Sec. 11. Minnesota Statutes 2015 Supplement, section 518A.39, subdivision 2, is
 78.25 amended to read:

78.26 **Subd. 2. Modification.** (a) The terms of an order respecting maintenance or support
 78.27 may be modified upon a showing of one or more of the following, any of which makes
 78.28 the terms unreasonable and unfair: (1) substantially increased or decreased gross income
 78.29 of an obligor or obligee; (2) substantially increased or decreased need of an obligor or
 78.30 obligee or the child or children that are the subject of these proceedings; (3) receipt of
 78.31 assistance under the AFDC program formerly codified under sections 256.72 to 256.87
 78.32 or 256B.01 to 256B.40, or chapter 256J or 256K; (4) a change in the cost of living for
 78.33 either party as measured by the Federal Bureau of Labor Statistics; (5) extraordinary
 78.34 medical expenses of the child not provided for under section 518A.41; (6) a change in
 78.35 the availability of appropriate health care coverage or a substantial increase or decrease

79.1 in health care coverage costs; (7) the addition of work-related or education-related child
79.2 care expenses of the obligee or a substantial increase or decrease in existing work-related
79.3 or education-related child care expenses; or (8) upon the emancipation of the child, as
79.4 provided in subdivision 5.

79.5 (b) It is presumed that there has been a substantial change in circumstances under
79.6 paragraph (a) and the terms of a current support order shall be rebuttably presumed to be
79.7 unreasonable and unfair if:

79.8 (1) the application of the child support guidelines in section 518A.35, to the current
79.9 circumstances of the parties results in a calculated court order that is at least 20 percent
79.10 and at least \$75 per month higher or lower than the current support order or, if the current
79.11 support order is less than \$75, it results in a calculated court order that is at least 20
79.12 percent per month higher or lower;

79.13 (2) the medical support provisions of the order established under section 518A.41
79.14 are not enforceable by the public authority or the obligee;

79.15 (3) health coverage ordered under section 518A.41 is not available to the child for
79.16 whom the order is established by the parent ordered to provide;

79.17 (4) the existing support obligation is in the form of a statement of percentage and not
79.18 a specific dollar amount;

79.19 (5) the gross income of an obligor or obligee has decreased by at least 20 percent
79.20 through no fault or choice of the party; or

79.21 (6) a deviation was granted based on the factor in section 518A.43, subdivision 1,
79.22 clause (4), and the child no longer resides in a foreign country or the factor is otherwise no
79.23 longer applicable.

79.24 (c) A child support order is not presumptively modifiable solely because an obligor
79.25 or obligee becomes responsible for the support of an additional nonjoint child, which is
79.26 born after an existing order. Section 518A.33 shall be considered if other grounds are
79.27 alleged which allow a modification of support.

79.28 (d) If child support was established by applying a parenting expense adjustment
79.29 or presumed equal parenting time calculation under previously existing child support
79.30 guidelines and there is no parenting plan or order from which overnights or overnight
79.31 equivalents can be determined, there is a rebuttable presumption that the established
79.32 adjustment or calculation shall continue after modification so long as the modification is
79.33 not based on a change in parenting time. In determining an obligation under previously
79.34 existing child support guidelines, it is presumed that the court shall:

80.1 (1) if a 12 percent parenting expense adjustment was applied, multiply the obligor's
80.2 share of the combined basic support obligation calculated under section 518A.34,
80.3 paragraph (b), clause (5), by 0.88; or

80.4 (2) if the parenting time was presumed equal but the parents' parental incomes for
80.5 determining child support were not equal:

80.6 (i) multiply the combined basic support obligation under section 518A.34, paragraph
80.7 (b), clause (5), by 0.075;

80.8 (ii) prorate the amount under item (i) between the parents based on each parent's
80.9 proportionate share of the combined PICS; and

80.10 (iii) subtract the lower amount from the higher amount.

80.11 (e) On a motion for modification of maintenance, including a motion for the
80.12 extension of the duration of a maintenance award, the court shall apply, in addition to all
80.13 other relevant factors, the factors for an award of maintenance under section 518.552 that
80.14 exist at the time of the motion. On a motion for modification of support, the court:

80.15 (1) shall apply section 518A.35, and shall not consider the financial circumstances of
80.16 each party's spouse, if any; and

80.17 (2) shall not consider compensation received by a party for employment in excess of
80.18 a 40-hour work week, provided that the party demonstrates, and the court finds, that:

80.19 (i) the excess employment began after entry of the existing support order;

80.20 (ii) the excess employment is voluntary and not a condition of employment;

80.21 (iii) the excess employment is in the nature of additional, part-time employment, or
80.22 overtime employment compensable by the hour or fractions of an hour;

80.23 (iv) the party's compensation structure has not been changed for the purpose of
80.24 affecting a support or maintenance obligation;

80.25 (v) in the case of an obligor, current child support payments are at least equal to the
80.26 guidelines amount based on income not excluded under this clause; and

80.27 (vi) in the case of an obligor who is in arrears in child support payments to the
80.28 obligee, any net income from excess employment must be used to pay the arrearages
80.29 until the arrearages are paid in full.

80.30 (~~e~~) (f) A modification of support or maintenance, including interest that accrued
80.31 pursuant to section 548.091, may be made retroactive only with respect to any period
80.32 during which the petitioning party has pending a motion for modification but only from
80.33 the date of service of notice of the motion on the responding party and on the public
80.34 authority if public assistance is being furnished or the county attorney is the attorney of
80.35 record, unless the court adopts an alternative effective date under paragraph (l). The

81.1 court's adoption of an alternative effective date under paragraph (l) shall not be considered
81.2 a retroactive modification of maintenance or support.

81.3 ~~(f)~~ (g) Except for an award of the right of occupancy of the homestead, provided
81.4 in section 518.63, all divisions of real and personal property provided by section 518.58
81.5 shall be final, and may be revoked or modified only where the court finds the existence
81.6 of conditions that justify reopening a judgment under the laws of this state, including
81.7 motions under section 518.145, subdivision 2. The court may impose a lien or charge on
81.8 the divided property at any time while the property, or subsequently acquired property, is
81.9 owned by the parties or either of them, for the payment of maintenance or support money,
81.10 or may sequester the property as is provided by section 518A.71.

81.11 ~~(g)~~ (h) The court need not hold an evidentiary hearing on a motion for modification
81.12 of maintenance or support.

81.13 ~~(h)~~ (i) Sections 518.14 and 518A.735 shall govern the award of attorney fees for
81.14 motions brought under this subdivision.

81.15 ~~(i)~~ (j) Except as expressly provided, an enactment, amendment, or repeal of law does
81.16 not constitute a substantial change in the circumstances for purposes of modifying a
81.17 child support order.

81.18 ~~(j)~~ MS 2006 [Expired]

81.19 ~~(k)~~ On the first modification ~~under the income shares method of calculation~~
81.20 following implementation of amended child support guidelines, the modification of basic
81.21 support may be limited if the amount of the full variance would create hardship for either
81.22 the obligor or the obligee.

81.23 (l) The court may select an alternative effective date for a maintenance or support
81.24 order if the parties enter into a binding agreement for an alternative effective date.

81.25 **EFFECTIVE DATE.** This section is effective August 1, 2018.

81.26 Sec. 12. **[518A.79] CHILD SUPPORT TASK FORCE.**

81.27 Subdivision 1. **Establishment; purpose.** There is established the Child Support
81.28 Task Force for the Department of Human Services. The purpose of the task force is to
81.29 advise the commissioner of human services on matters relevant to maintaining effective
81.30 and efficient child support guidelines that will best serve the children of Minnesota and
81.31 take into account the changing dynamics of families.

81.32 Subd. 2. **Members.** (a) The task force must consist of:

81.33 (1) two members of the house of representatives, one appointed by the speaker of the
81.34 house and one appointed by the minority leader;

82.1 (2) two members of the senate, one appointed by the majority leader and one
 82.2 appointed by the minority leader;

82.3 (3) one representative from the Minnesota County Attorneys Association;

82.4 (4) one staff member from the Department of Human Services Child Support
 82.5 Division;

82.6 (5) one representative from a tribe with an approved IV-D program appointed by
 82.7 resolution of the Minnesota Indian Affairs Council;

82.8 (6) one representative from the Minnesota Family Support Recovery Council;

82.9 (7) one child support magistrate, family court referee, or one district court judge or
 82.10 retired judge with experience in child support matters, appointed by the chief justice of
 82.11 the Supreme Court;

82.12 (8) four parents, at least two of whom represent diverse cultural and social
 82.13 communities, appointed by the commissioner with equal representation between custodial
 82.14 and noncustodial parents;

82.15 (9) one representative from the Minnesota Legal Services Coalition; and

82.16 (10) one representative from the Family Law Section of the Minnesota Bar
 82.17 Association.

82.18 (b) Section 15.059 governs the Child Support Task Force.

82.19 (c) Members of the task force shall be compensated as provided in section 15.059,
 82.20 subdivision 3.

82.21 Subd. 3. **Organization.** (a) The commissioner or the commissioner's designee shall
 82.22 convene the first meeting of the task force.

82.23 (b) The members of the task force shall annually elect a chair and other officers
 82.24 as the members deem necessary.

82.25 (c) The task force shall meet at least three times per year, with one meeting devoted
 82.26 to collecting input from the public.

82.27 Subd. 4. **Staff.** The commissioner shall provide support staff, office space, and
 82.28 administrative services for the task force.

82.29 Subd. 5. **Duties of the task force.** (a) General duties of the task force include, but
 82.30 are not limited to:

82.31 (1) serving in an advisory capacity to the commissioner of human services;

82.32 (2) reviewing the effects of implementing the parenting expense adjustment enacted
 82.33 by the 2016 legislature;

82.34 (3) at least every four years, preparing for and advising the commissioner on the
 82.35 development of the quadrennial review report;

82.36 (4) collecting and studying information and data relating to child support awards; and

83.1 (5) conducting a comprehensive review of child support guidelines, economic
 83.2 conditions, and other matters relevant to maintaining effective and efficient child support
 83.3 guidelines.

83.4 (b) The task force must review, address, and make recommendations on the
 83.5 following priority issues:

83.6 (1) the self-support reserve for custodial and noncustodial parents;

83.7 (2) simultaneous child support orders;

83.8 (3) obligors who are subject to child support orders in multiple counties;

83.9 (4) parents with multiple families;

83.10 (5) non-nuclear families, such as grandparents, relatives, and foster parents who
 83.11 are caretakers of children;

83.12 (6) standards to apply for modifications; and

83.13 (7) updating section 518A.35, subdivision 2, the guideline for basic support.

83.14 Subd. 6. **Consultation.** The chair of the task force must consult with the Cultural
 83.15 and Ethnic Communities Leadership Council at least annually on the issues under
 83.16 consideration by the task force.

83.17 Subd. 7. **Report and recommendations.** Beginning February 15, 2018, and
 83.18 biennially thereafter, if the task force is extended by the legislature, the commissioner
 83.19 shall prepare and submit to the chairs and ranking minority members of the committees of
 83.20 the house of representatives and the senate with jurisdiction over child support matters a
 83.21 report that summarizes the activities of the task force, issues identified by the task force,
 83.22 methods taken to address the issues, and recommendations for legislative action, if needed.

83.23 Subd. 8. **Expiration.** The task force expires June 30, 2019, unless extended by
 83.24 the legislature.

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

83.26 Sec. 13. Minnesota Statutes 2014, section 626.558, subdivision 1, is amended to read:

83.27 Subdivision 1. **Establishment of team.** A county shall establish a multidisciplinary
 83.28 child protection team that may include, but not be limited to, the director of the local
 83.29 welfare agency or designees, the county attorney or designees, the county sheriff or
 83.30 designees, representatives of health and education, representatives of mental health or
 83.31 other appropriate human service or community-based agencies, and parent groups. As
 83.32 used in this section, a "community-based agency" may include, but is not limited to,
 83.33 schools, social service agencies, family service and mental health collaboratives, children's
 83.34 advocacy centers, early childhood and family education programs, Head Start, or other
 83.35 agencies serving children and families. A member of the team must be designated as the

84.1 lead person of the team responsible for the planning process to develop standards for its
84.2 activities with battered women's and domestic abuse programs and services.

84.3 Sec. 14. Minnesota Statutes 2014, section 626.558, subdivision 2, is amended to read:

84.4 Subd. 2. **Duties of team.** A multidisciplinary child protection team may provide
84.5 public and professional education, develop resources for prevention, intervention, and
84.6 treatment, and provide case consultation to the local welfare agency or other interested
84.7 community-based agencies. The community-based agencies may request case consultation
84.8 from the multidisciplinary child protection team regarding a child or family for whom the
84.9 community-based agency is providing services. As used in this section, "case consultation"
84.10 means a case review process in which recommendations are made concerning services to
84.11 be provided to the identified children and family. Case consultation may be performed by
84.12 a committee or subcommittee of members representing human services, including mental
84.13 health and chemical dependency; law enforcement, including probation and parole; the
84.14 county attorney; a children's advocacy center; health care; education; community-based
84.15 agencies and other necessary agencies; and persons directly involved in an individual case
84.16 as designated by other members performing case consultation.

84.17 Sec. 15. Minnesota Statutes 2014, section 626.558, is amended by adding a subdivision
84.18 to read:

84.19 Subd. 4. **Children's advocacy center; definition.** (a) For purposes of this section,
84.20 "children's advocacy center" means an organization, using a multidisciplinary team
84.21 approach, whose primary purpose is to provide children who have been the victims of
84.22 abuse and their nonoffending family members with:

- 84.23 (1) support and advocacy;
84.24 (2) specialized medical evaluation;
84.25 (3) trauma-focused mental health services; and
84.26 (4) forensic interviews.

84.27 (b) Children's advocacy centers provide multidisciplinary case review and the
84.28 tracking and monitoring of case progress.

84.29 Sec. 16. **CHILD CARE PROVIDER LIAISON AND ADVOCATE.**

84.30 The commissioner of human services must designate a full-time employee of
84.31 the department to serve as a child care provider liaison and advocate. The child care
84.32 provider liaison and advocate must be responsive to requests from providers by providing

85.1 information or assistance in obtaining or renewing licenses, meeting state regulatory
85.2 requirements, or resolving disputes with state agencies or other political subdivisions.

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

85.4 Sec. 17. **LEGISLATIVE TASK FORCE ON CHILD CARE.**

85.5 Subdivision 1. **Creation.** A legislative task force on child care is created to review
85.6 the loss of child care providers in the state, assess affordability issues for providers and
85.7 parents, and identify areas that need to be addressed by the legislature.

85.8 Subd. 2. **Membership.** Task force members shall include:

85.9 (1) four members from the house of representatives appointed by the speaker of the
85.10 house, two from the majority party and two from the minority party; and

85.11 (2) four members from the senate appointed by the majority leader, two from the
85.12 majority party and two from the minority party.

85.13 Subd. 3. **Duties.** (a) The task force may:

85.14 (1) evaluate factors that contribute to child care costs for providers and families;

85.15 (2) assess the child care provider shortage in greater Minnesota;

85.16 (3) review the current preservice and in-service training requirements for family
85.17 child care providers and child care center staff. The review shall include training required
85.18 for licensure, including staff credentialing for child care center staff positions and the ways
85.19 in which the training aligns with Minnesota's Career Lattice and Minnesota's Knowledge
85.20 and Competency Framework for Early Childhood and School-Aged Care Practitioners;

85.21 (4) review the availability of training that is in place to meet the training needs of
85.22 providers, including the content of the training, cost, and delivery methods;

85.23 (5) consider creation of a board of child care to be responsible for all matters related
85.24 to licensing of child care providers, both in-home and center-based programs, and to
85.25 employ an advocate for child care providers;

85.26 (6) review the process of issuing and resolving correction orders issued to child
85.27 care providers;

85.28 (7) consider uniform training requirements for county employees and their
85.29 supervisors who perform duties related to licensing;

85.30 (8) review progress being made by the commissioner of human services to streamline
85.31 paperwork and reduce redundancies for child care providers;

85.32 (9) review the time it takes for the department to provide child care assistance
85.33 program reimbursement to providers; and

85.34 (10) consider options for conducting exit interviews with providers who leave the
85.35 child care field or choose not to be relicensed.

86.1 (b) Task force members may receive input from the commissioners of human
86.2 services and economic development, providers, and stakeholders to review all action items.

86.3 Subd. 4. **Recommendations and report.** The task force, in cooperation with the
86.4 commissioner of human services, shall issue a report to the legislature and governor by
86.5 December 31, 2016. The report must contain summary information obtained during
86.6 the task force meetings and recommendations for additional legislative changes and
86.7 procedures affecting child care.

86.8 **EFFECTIVE DATE.** This section is effective the day following final enactment
86.9 and sunsets on December 31, 2016.

86.10 Sec. 18. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET**
86.11 **EXCLUSION.**

86.12 (a) The commissioner of human services shall not count payments made to families
86.13 by the income and child development in the first three years of life demonstration
86.14 project as income or assets for purposes of determining or redetermining eligibility for
86.15 child care assistance programs under Minnesota Statutes, chapter 119B; the Minnesota
86.16 family investment program, work benefit program, or diversionary work program under
86.17 Minnesota Statutes, chapter 256J, during the duration of the demonstration.

86.18 (b) The commissioner of human services shall not count payments made to families
86.19 by the income and child development in the first three years of life demonstration project
86.20 as income for purposes of determining or redetermining eligibility for medical assistance
86.21 under Minnesota Statutes, chapter 256B, and MinnesotaCare under Minnesota Statutes,
86.22 chapter 256L.

86.23 (c) For the purposes of this section, "income and child development in the first
86.24 three years of life demonstration project" means a demonstration project funded by the
86.25 United States Department of Health and Human Services National Institutes of Health to
86.26 evaluate whether the unconditional cash payments have a causal effect on the cognitive,
86.27 socioemotional, and brain development of infants and toddlers.

86.28 (d) This section shall only be implemented if Minnesota is chosen as a site for
86.29 the child development in the first three years of life demonstration project, and expires
86.30 January 1, 2022.

86.31 (e) The commissioner of human services shall provide a report to the chairs and
86.32 ranking minority members of the legislative committees having jurisdiction over human
86.33 services issues by January 1, 2023, informing the legislature on the progress and outcomes
86.34 of the demonstration under this section.

87.1 **EFFECTIVE DATE.** Paragraph (b) is effective August 16, 2016, or upon federal
87.2 approval, whichever is later.

87.3 Sec. 19. **REPEALER; HANDS OFF CHILD CARE.**

87.4 Minnesota Statutes 2014, sections 179A.50; 179A.51; 179A.52; and 179A.53, are
87.5 repealed.

87.6 **ARTICLE 7**

87.7 **HEALTH-RELATED LICENSING**

87.8 **GENETIC COUNSELORS**

87.9 Section 1. **[147F.01] DEFINITIONS.**

87.10 Subdivision 1. **Applicability.** For purposes of sections 147F.01 to 147F.17, the
87.11 terms defined in this section have the meanings given them.

87.12 Subd. 2. **ABGC.** "ABGC" means the American Board of Genetic Counseling, a
87.13 national agency for certification and recertification of genetic counselors, or its successor
87.14 organization or equivalent.

87.15 Subd. 3. **ABMG.** "ABMG" means the American Board of Medical Genetics,
87.16 a national agency for certification and recertification of genetic counselors, medical
87.17 geneticists, and Ph.D. geneticists, or its successor organization.

87.18 Subd. 4. **ACGC.** "ACGC" means the Accreditation Council for Genetic Counseling,
87.19 a specialized program accreditation board for educational training programs granting
87.20 master's degrees or higher in genetic counseling, or its successor organization.

87.21 Subd. 5. **Board.** "Board" means the Board of Medical Practice.

87.22 Subd. 6. **Eligible status.** "Eligible status" means an applicant who has met the
87.23 requirements and received approval from the ABGC to sit for the certification examination.

87.24 Subd. 7. **Genetic counseling.** "Genetic counseling" means the provision of services
87.25 described in section 147F.03 to help clients and their families understand the medical,
87.26 psychological, and familial implications of genetic contributions to a disease or medical
87.27 condition.

87.28 Subd. 8. **Genetic counselor.** "Genetic counselor" means an individual licensed
87.29 under sections 147F.01 to 147F.17 to engage in the practice of genetic counseling.

87.30 Subd. 9. **Licensed physician.** "Licensed physician" means an individual who is
87.31 licensed to practice medicine under chapter 147.

88.1 Subd. 10. **NSGC.** "NSGC" means the National Society of Genetic Counselors, a
88.2 professional membership association for genetic counselors that approves continuing
88.3 education programs.

88.4 Subd. 11. **Qualified supervisor.** "Qualified supervisor" means any person who is
88.5 licensed under sections 147F.01 to 147F.17 as a genetic counselor or a physician licensed
88.6 under chapter 147 to practice medicine in Minnesota.

88.7 Subd. 12. **Supervisee.** "Supervisee" means a genetic counselor with a provisional
88.8 license.

88.9 Subd. 13. **Supervision.** "Supervision" means an assessment of the work of the
88.10 supervisee, including regular meetings and file review, by a qualified supervisor according
88.11 to the supervision contract. Supervision does not require the qualified supervisor to be
88.12 present while the supervisee provides services.

88.13 **Sec. 2. [147F.03] SCOPE OF PRACTICE.**

88.14 The practice of genetic counseling by a licensed genetic counselor includes the
88.15 following services:

88.16 (1) obtaining and interpreting individual and family medical and developmental
88.17 histories;

88.18 (2) determining the mode of inheritance and the risk of transmitting genetic
88.19 conditions and birth defects;

88.20 (3) discussing the inheritance, features, natural history, means of diagnosis, and
88.21 management of conditions with clients;

88.22 (4) identifying, coordinating, ordering, and explaining the clinical implications of
88.23 genetic laboratory tests and other laboratory studies;

88.24 (5) assessing psychosocial factors, including social, educational, and cultural issues;

88.25 (6) providing client-centered counseling and anticipatory guidance to the client or
88.26 family based on their responses to the condition, risk of occurrence, or risk of recurrence;

88.27 (7) facilitating informed decision-making about testing and management;

88.28 (8) identifying and using community resources that provide medical, educational,
88.29 financial, and psychosocial support and advocacy; and

88.30 (9) providing accurate written medical, genetic, and counseling information for
88.31 families and health care professionals.

88.32 **Sec. 3. [147F.05] UNLICENSED PRACTICE PROHIBITED; PROTECTED**
88.33 **TITLES AND RESTRICTIONS ON USE.**

89.1 Subdivision 1. **Protected titles.** No individual may use the title "genetic counselor,"
89.2 "licensed genetic counselor," "gene counselor," "genetic consultant," "genetic assistant,"
89.3 "genetic associate," or any words, letters, abbreviations, or insignia indicating or implying
89.4 that the individual is eligible for licensure by the state as a genetic counselor unless the
89.5 individual has been licensed as a genetic counselor according to sections 147F.01 to
89.6 147F.17.

89.7 Subd. 2. **Unlicensed practice prohibited.** Effective January 1, 2018, no individual
89.8 may practice genetic counseling unless the individual is licensed as a genetic counselor
89.9 sections 147F.01 to 147F.17 except as otherwise provided under sections 147F.01 to
89.10 147F.17.

89.11 Subd. 3. **Other practitioners.** (a) Nothing in sections 147F.01 to 147F.17 shall be
89.12 construed to prohibit or restrict the practice of any profession or occupation licensed
89.13 or registered by the state by an individual duly licensed or registered to practice the
89.14 profession or occupation or to perform any act that falls within the scope of practice
89.15 of the profession or occupation.

89.16 (b) Nothing in sections 147F.01 to 147F.17 shall be construed to require a license
89.17 under sections 147F.01 to 147F.17 for:

89.18 (1) an individual employed as a genetic counselor by the federal government or a
89.19 federal agency if the individual is providing services under the direction and control of
89.20 the employer;

89.21 (2) a student or intern, having graduated within the past six months, or currently
89.22 enrolled in an ACGC-accredited genetic counseling educational program providing
89.23 genetic counseling services that are an integral part of the student's or intern's course
89.24 of study, are performed under the direct supervision of a licensed genetic counselor or
89.25 physician who is on duty in the assigned patient care area, and the student is identified by
89.26 the title "genetic counseling intern";

89.27 (3) a visiting ABGC- or ABMG-certified genetic counselor working as a consultant
89.28 in this state who permanently resides outside of the state, or the occasional use of services
89.29 from organizations from outside of the state that employ ABGC- or ABMG-certified
89.30 genetic counselors. This is limited to practicing for 30 days total within one calendar year.
89.31 Certified genetic counselors from outside of the state working as a consultant in this state
89.32 must be licensed in their state of residence if that credential is available; or

89.33 (4) an individual who is licensed to practice medicine under chapter 147.

89.34 Subd. 4. **Sanctions.** An individual who violates this section is guilty of a
89.35 misdemeanor and shall be subject to sanctions or actions according to section 214.11.

90.1 Sec. 4. [147F.07] LICENSURE REQUIREMENTS.

90.2 Subdivision 1. General requirements for licensure. To be eligible for licensure, an
90.3 applicant, with the exception of those seeking licensure by reciprocity under subdivision
90.4 2, must submit to the board:

90.5 (1) a completed application on forms provided by the board along with all fees
90.6 required under section 147F.17. The applicant must include:

90.7 (i) the applicant's name, Social Security number, home address and telephone
90.8 number, and business address and telephone number if currently employed;

90.9 (ii) the name and location of the genetic counseling or medical program the applicant
90.10 completed;

90.11 (iii) a list of degrees received from other educational institutions;

90.12 (iv) a description of the applicant's professional training;

90.13 (v) a list of registrations, certifications, and licenses held in other jurisdictions;

90.14 (vi) a description of any other jurisdiction's refusal to credential the applicant;

90.15 (vii) a description of all professional disciplinary actions initiated against the
90.16 applicant in any jurisdiction; and

90.17 (viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

90.18 (2) evidence of graduation from an education program accredited by the ACGC or
90.19 its predecessor or successor organization;

90.20 (3) a verified copy of a valid and current certification issued by the ABGC or ABMG
90.21 as a certified genetic counselor, or by the ABMG as a certified medical geneticist;

90.22 (4) additional information as requested by the board, including any additional
90.23 information necessary to ensure that the applicant is able to practice with reasonable skill
90.24 and safety to the public;

90.25 (5) a signed statement verifying that the information in the application is true and
90.26 correct to the best of the applicant's knowledge and belief; and

90.27 (6) a signed waiver authorizing the board to obtain access to the applicant's records
90.28 in this or any other state in which the applicant completed an educational program or
90.29 engaged in the practice of genetic counseling.

90.30 Subd. 2. Licensure by reciprocity. To be eligible for licensure by reciprocity,
90.31 the applicant must hold a current genetic counselor or medical geneticist registration
90.32 or license in another state, the District of Columbia, or a territory of the United States,
90.33 whose standards for registration or licensure are at least equivalent to those of Minnesota,
90.34 and must:

90.35 (1) submit the application materials and fees as required by subdivision 1, clauses
90.36 (1), (2), and (4) to (6);

91.1 (2) provide a verified copy from the appropriate government body of a current
91.2 registration or license for the practice of genetic counseling in another jurisdiction that has
91.3 initial registration or licensing requirements equivalent to or higher than the requirements
91.4 in subdivision 1; and

91.5 (3) provide letters of verification from the appropriate government body in each
91.6 jurisdiction in which the applicant holds a registration or license. Each letter must state
91.7 the applicant's name, date of birth, registration or license number, date of issuance, a
91.8 statement regarding disciplinary actions, if any, taken against the applicant, and the terms
91.9 under which the registration or license was issued.

91.10 Subd. 3. **Licensure by equivalency.** (a) The board may grant a license to an
91.11 individual who does not meet the certification requirements in subdivision 1 but who
91.12 has been employed as a genetic counselor for a minimum of ten years and provides the
91.13 following documentation to the board no later than February 1, 2018:

91.14 (1) proof of a master's or higher degree in genetics or related field of study from an
91.15 accredited educational institution;

91.16 (2) proof that the individual has never failed the ABGC or ABMG certification
91.17 examination;

91.18 (3) three letters of recommendation, with at least one from an individual eligible for
91.19 licensure under sections 147F.01 to 147F.17, and at least one from an individual certified
91.20 as a genetic counselor by the ABGC or ABMG or an individual certified as a medical
91.21 geneticist by the ABMG. An individual who submits a letter of recommendation must
91.22 have worked with the applicant in an employment setting during the past ten years and
91.23 must attest to the applicant's competency; and

91.24 (4) documentation of the completion of 100 hours of NSGC-approved continuing
91.25 education credits within the past five years.

91.26 (b) This subdivision expires February 1, 2018.

91.27 Subd. 4. **License expiration.** A genetic counselor license shall be valid for one
91.28 year from the date of issuance.

91.29 Subd. 5. **License renewal.** To be eligible for license renewal, a licensed genetic
91.30 counselor must submit to the board:

91.31 (1) a renewal application on a form provided by the board;

91.32 (2) the renewal fee required under section 147F.17;

91.33 (3) evidence of compliance with the continuing education requirements in section
91.34 147F.11; and

91.35 (4) any additional information requested by the board.

92.1 Sec. 5. **[147F.09] BOARD ACTION ON APPLICATIONS FOR LICENSURE.**

92.2 (a) The board shall act on each application for licensure according to paragraphs
 92.3 (b) to (d).

92.4 (b) The board shall determine if the applicant meets the requirements for licensure
 92.5 under section 147F.07. The board may investigate information provided by an applicant to
 92.6 determine whether the information is accurate and complete.

92.7 (c) The board shall notify each applicant in writing of action taken on the application,
 92.8 the grounds for denying licensure if a license is denied, and the applicant's right to review
 92.9 the board's decision under paragraph (d).

92.10 (d) Applicants denied licensure may make a written request to the board, within 30
 92.11 days of the board's notice, to appear before the advisory council and for the advisory
 92.12 council to review the board's decision to deny the applicant's license. After reviewing the
 92.13 denial, the advisory council shall make a recommendation to the board as to whether
 92.14 the denial shall be affirmed. Each applicant is allowed only one request for review per
 92.15 licensure period.

92.16 Sec. 6. **[147F.11] CONTINUING EDUCATION REQUIREMENTS.**

92.17 (a) A licensed genetic counselor must complete a minimum of 25 hours of NSGC-
 92.18 or ABMG-approved continuing education units every two years. If a licensee's renewal
 92.19 term is prorated to be more or less than one year, the required number of continuing
 92.20 education units is prorated proportionately.

92.21 (b) The board may grant a variance to the continuing education requirements
 92.22 specified in this section if a licensee demonstrates to the satisfaction of the board that the
 92.23 licensee is unable to complete the required number of educational units during the renewal
 92.24 term. The board may allow the licensee to complete the required number of continuing
 92.25 education units within a time frame specified by the board. In no case shall the board
 92.26 allow the licensee to complete less than the required number of continuing education units.

92.27 Sec. 7. **[147F.13] DISCIPLINE; REPORTING.**

92.28 For purposes of sections 147F.01 to 147F.17, licensed genetic counselors and
 92.29 applicants are subject to sections 147.091 to 147.162.

92.30 Sec. 8. **[147F.15] LICENSED GENETIC COUNSELOR ADVISORY COUNCIL.**

92.31 Subdivision 1. **Membership.** The board shall appoint a five-member Licensed
 92.32 Genetic Counselor Advisory Council. One member must be a licensed physician with

93.1 experience in genetics, three members must be licensed genetic counselors, and one
93.2 member must be a public member.

93.3 Subd. 2. **Organization.** The advisory council shall be organized and administered
93.4 as provided in section 15.059.

93.5 Subd. 3. **Duties.** The advisory council shall:

93.6 (1) advise the board regarding standards for licensed genetic counselors;

93.7 (2) provide for distribution of information regarding licensed genetic counselor
93.8 practice standards;

93.9 (3) advise the board on enforcement of sections 147F.01 to 147F.17;

93.10 (4) review applications and recommend granting or denying licensure or license
93.11 renewal;

93.12 (5) advise the board on issues related to receiving and investigating complaints,
93.13 conducting hearings, and imposing disciplinary action in relation to complaints against
93.14 licensed genetic counselors; and

93.15 (6) perform other duties authorized for advisory councils by chapter 214, as directed
93.16 by the board.

93.17 Subd. 4. **Expiration.** Notwithstanding section 15.059, the advisory council does
93.18 not expire.

93.19 Sec. 9. **[147F.17] FEES.**

93.20 Subdivision 1. **Fees.** Fees are as follows:

93.21 (1) license application fee, \$200;

93.22 (2) initial licensure and annual renewal, \$150;

93.23 (3) provisional license fee, \$150; and

93.24 (4) late fee, \$75.

93.25 Subd. 2. **Proration of fees.** The board may prorate the initial license fee. All
93.26 licensees are required to pay the full fee upon license renewal.

93.27 Subd. 3. **Penalty for late renewals.** An application for registration renewal
93.28 submitted after the deadline must be accompanied by a late fee in addition to the required
93.29 fees.

93.30 Subd. 4. **Nonrefundable fees.** All fees are nonrefundable.

93.31 Subd. 5. **Deposit.** Fees collected by the board under this section shall be deposited
93.32 in the state government special revenue fund.

93.33 **MESSAGE AND BODYWORK THERAPY ACT**

93.34 Sec. 10. **[148.981] CITATION.**

94.1 Sections 148.981 to 148.9886 may be cited as the "Minnesota Massage and
94.2 Bodywork Therapy Act."

94.3 **EFFECTIVE DATE.** This section is effective August 1, 2016.

94.4 Sec. 11. **[148.982] DEFINITIONS.**

94.5 Subdivision 1. **Applicability.** The definitions in this section apply to sections
94.6 148.981 to 148.9885.

94.7 Subd. 2. **Advertise.** "Advertise" means to publish, display, broadcast, or disseminate
94.8 information by any means that can be reasonably construed as an advertisement.

94.9 Subd. 3. **Advisory council.** "Advisory council" means the Registered Massage and
94.10 Bodywork Therapist Advisory Council established under section 148.9861.

94.11 Subd. 4. **Applicant.** "Applicant" means an individual applying for registration or
94.12 renewal according to sections 148.981 to 148.9886.

94.13 Subd. 5. **Board.** "Board" means the Minnesota Board of Nursing.

94.14 Subd. 6. **Client.** "Client" means a recipient of massage and bodywork therapy
94.15 services.

94.16 Subd. 7. **Competency exam.** "Competency exam" means a massage and bodywork
94.17 therapy competency assessment that is approved by the board and is psychometrically
94.18 valid, based on a job task analysis, and administered by a national testing organization.

94.19 Subd. 8. **Contact hour.** "Contact hour" means an instructional session of at least
94.20 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker,
94.21 and social activities.

94.22 Subd. 9. **Credential.** "Credential" means a license, registration, or certification.

94.23 Subd. 10. **Health care provider.** "Health care provider" means a person who has a
94.24 state credential to provide one or more of the following services: medical as defined in
94.25 section 147.081, chiropractic as defined in section 148.01, podiatry as defined in section
94.26 153.01, dentistry as defined in section 150A.01, physical therapy as defined in section
94.27 148.65, or other state-credentialed providers.

94.28 Subd. 11. **Massage and bodywork therapy.** "Massage and bodywork therapy"
94.29 means a health care service involving systematic and structured touch and palpation, and
94.30 pressure and movement of the muscles, tendons, ligaments, and fascia, in order to reduce
94.31 muscle tension, relieve soft tissue pain, improve circulation, increase flexibility, increase
94.32 activity of the parasympathetic branch of the autonomic nervous system, or to promote
94.33 general wellness, by use of the techniques and applications described in section 148.983.
94.34 This definition applies to massage and bodywork therapy performed by individuals

95.1 registered under sections 148.981 to 148.9886, and does not apply to practitioners who
95.2 provide complementary and alternative health care under chapter 146A.

95.3 Subd. 12. **Municipality.** "Municipality" means a county, town, or home rule
95.4 charter or statutory city.

95.5 Subd. 13. **Physical agent modality.** "Physical agent modality" means modalities
95.6 that use the properties of light, water, temperature, sound, and electricity to produce
95.7 a response in soft tissue.

95.8 Subd. 14. **Practice of massage and bodywork therapy.** "Practice of massage and
95.9 bodywork therapy" means to engage professionally for compensation or as a volunteer in
95.10 massage and bodywork therapy or the instruction of professional technique coursework.
95.11 This definition applies to massage and bodywork therapy performed by individuals
95.12 registered under sections 148.981 to 148.9886, and does not apply to practitioners who
95.13 provide complementary and alternative health care under chapter 146A.

95.14 Subd. 15. **Professional organization.** "Professional organization" means an
95.15 organization that represents massage and bodywork therapists, was established before
95.16 the year 2005, offers professional liability insurance as a benefit of membership, has an
95.17 established code of professional ethics, and is board approved.

95.18 Subd. 16. **Registered massage and bodywork therapist or registrant.** "Registered
95.19 massage and bodywork therapist" or "registrant" means a health care provider registered
95.20 according to sections 148.981 to 148.9886, for the practice of massage and bodywork
95.21 therapy.

95.22 Subd. 17. **State.** "State" means any state in the United States, the District of
95.23 Columbia, Puerto Rico, the United States Virgin Islands, or Guam; or any Canadian
95.24 province or similar political subdivision of a foreign country; except "this state" means the
95.25 state of Minnesota.

95.26 **EFFECTIVE DATE.** This section is effective August 1, 2016.

95.27 Sec. 12. **[148.983] MASSAGE AND BODYWORK THERAPY.**

95.28 (a) For purposes of sections 148.981 to 148.9886, the practice of massage and
95.29 bodywork therapy by a registered massage and bodywork therapist includes the following:

95.30 (1) use of any or all of the following techniques using the hands, forearms, elbows,
95.31 knees, or feet, or handheld, nonpuncturing, mechanical, or electrical devices that
95.32 mimic or enhance the actions of the human hands: effleurage or gliding; petrissage or
95.33 kneading; vibration and jostling; friction; tapotement or percussion; compression; fascial
95.34 manipulation; passive stretching within the normal anatomical range of motion; and

96.1 (2) application and use of any of the following: oils, lotions, gels, rubbing alcohol, or
96.2 powders for the purpose of lubricating the skin to be massaged; creams, with the exception
96.3 of prescription medicinal creams; hot or cold stones; essential oils as used in aromatherapy
96.4 for inhalation or diluted for topical application; salt glows and wraps; or heat or ice.

96.5 (b) The practice of massage and bodywork therapy does not include any of the
96.6 following:

96.7 (1) diagnosing any illness or disease;

96.8 (2) altering a course of recommended massage and bodywork therapy when
96.9 recommended by a state-credentialed health care provider without first consulting that
96.10 health care provider;

96.11 (3) prescription of drugs or medicines;

96.12 (4) intentional adjustment, manipulation, or mobilization of abnormal articulations,
96.13 neurological disturbances, structural alterations, biomechanical alterations as described in
96.14 section 148.01, including by means of a high-velocity, low-amplitude thrusting force or by
96.15 means of manual therapy or mechanical therapy for the manipulation or adjustment of
96.16 joint articulation as defined in section 146.23; or

96.17 (5) application of physical agent modalities, needles that puncture the skin, or
96.18 injection therapy.

96.19 **EFFECTIVE DATE.** This section is effective August 1, 2016.

96.20 Sec. 13. **[148.984] LIMITATIONS ON PRACTICE.**

96.21 If a reasonably prudent massage and bodywork therapist finds a client's medical
96.22 condition is beyond the scope of practice established by sections 148.981 to 148.9886, or
96.23 by rules of the board for a registered massage and bodywork therapist, the massage and
96.24 bodywork therapist must refer the client to a health care provider as defined in sections
96.25 148.981 to 148.9885, but is not prohibited from comanaging the client.

96.26 **EFFECTIVE DATE.** This section is effective August 1, 2016.

96.27 Sec. 14. **[148.985] PROTECTED TITLES AND RESTRICTIONS ON USE.**

96.28 Subdivision 1. **Designation.** An individual regulated by sections 148.981 to
96.29 148.9886, is designated as a "registered massage and bodywork therapist" or "RMBT."

96.30 Subd. 2. **Title protection.** Effective July 1, 2017, no individual may use the title
96.31 "registered massage and bodywork therapist," or use, in connection with the individual's
96.32 name, the letters "RMBT," or any other titles, words, letters, abbreviations, or insignia
96.33 indicating or implying that the individual is registered or eligible for registration by this

97.1 state as a registered massage therapist unless the individual has been registered under
97.2 sections 148.981 to 148.9886.

97.3 Subd. 3. **Identification of registrants.** (a) A massage and bodywork therapist
97.4 registered according to sections 148.981 to 148.9886 shall be identified as a "registered
97.5 massage and bodywork therapist." If not written in full, this must be designated as "RMBT."

97.6 (b) The board may adopt rules for the implementation of this section, including the
97.7 identification of terms or references that may be used only by registered massage and
97.8 bodywork therapists as necessary to protect the public.

97.9 (c) A massage and bodywork therapist who is credentialed by another state, or who
97.10 holds a certification from organizations, agencies, or educational providers may advertise
97.11 using those terms or letters to indicate that credential, provided that the credentialing
97.12 body is clearly identified.

97.13 Subd. 4. **Other health care providers.** Nothing in sections 148.981 to 148.9886
97.14 may be construed to prohibit, restrict the practice of, or require massage and bodywork
97.15 therapy registration of any of the following:

97.16 (1) a health care provider credentialed by this state, using massage and bodywork
97.17 therapy techniques within the scope of the provider's credential, provided the provider does
97.18 not advertise or imply that they are registered according to sections 148.981 to 148.9886; or

97.19 (2) a practitioner who is engaged in providing complementary and alternative health
97.20 care practices as defined in section 146A.01, subdivision 4, provided that the practitioner
97.21 does not advertise or imply that they are registered according to sections 148.981 to
97.22 148.9886.

97.23 **EFFECTIVE DATE.** This section is effective August 1, 2016.

97.24 Sec. 15. **[148.986] POWERS OF BOARD.**

97.25 The board, acting with the advice of the advisory council, shall issue registrations to
97.26 duly qualified applicants and shall exercise the following powers and duties:

97.27 (1) adopt rules, including standards of practice and a professional code of ethics,
97.28 consistent with the law, as may be necessary to enable the board to implement the
97.29 provisions of sections 148.981 to 148.9886;

97.30 (2) assign duties to the advisory council that are necessary to implement the
97.31 provisions of sections 148.981 to 148.9886;

97.32 (3) approve or conduct a competency exam;

97.33 (4) enforce sections 148.981 to 148.9886, including by causing the prosecution for
97.34 violations of section 148.9882 by a registrant or applicant; impose discipline as described
97.35 in section 148.9882, and incur any necessary expense;

- 98.1 (5) maintain a record of names and addresses of registrants;
 98.2 (6) keep a permanent record of all its proceedings;
 98.3 (7) distribute information regarding massage and bodywork therapy standards,
 98.4 including applications and forms necessary to carry into effect the provisions of sections
 98.5 148.981 to 148.9886;
 98.6 (8) take action on applications according to section 148.9881; and
 98.7 (9) employ and establish the duties of necessary personnel.

98.8 **EFFECTIVE DATE.** This section is effective August 1, 2016.

98.9 **Sec. 16. [148.9861] REGISTERED MASSAGE AND BODYWORK THERAPIST**
 98.10 **ADVISORY COUNCIL.**

98.11 **Subdivision 1. Creation; membership.** (a) The Registered Massage and Bodywork
 98.12 Therapist Advisory Council is created and is composed of five members appointed by
 98.13 the board. All members must have resided in this state for at least three years prior to
 98.14 appointment. The advisory council consists of:

- 98.15 (1) two public members, as defined in section 214.02;
 98.16 (2) three members who, except for initial appointees, are registered massage and
 98.17 bodywork therapists. Initial appointees must practice massage and bodywork therapy.
 98.18 An initial appointee shall be removed from the council if the appointee does not obtain
 98.19 registration under section 148.987 within a reasonable time after registration procedures
 98.20 are established.

98.21 (b) A person may not be appointed to serve more than two consecutive full terms.

98.22 (c) No more than one member of the advisory council may be an owner or
 98.23 administrator of a massage and bodywork therapy education provider.

98.24 **Subd. 2. Vacancies.** When a vacancy occurs for a member who is a registered
 98.25 massage and bodywork therapist, the board may appoint a member from among qualified
 98.26 candidates or from a list of nominees submitted by professional organizations that contains
 98.27 twice the number of nominees as vacancies. The board may fill vacancies occurring on
 98.28 the advisory council for unexpired terms according to this section. Members shall retain
 98.29 membership until a qualified successor is appointed.

98.30 **Subd. 3. Administration.** The advisory council shall be organized and administered
 98.31 under section 15.059. The council shall not expire.

98.32 **Subd. 4. Duties.** The advisory council shall advise the board regarding:

- 98.33 (1) establishment of standards of practice and a code of ethics for registered massage
 98.34 and bodywork therapists;
 98.35 (2) distribution of information regarding massage and bodywork standards;

- 99.1 (3) enforcement of sections 148.981 to 148.9886;
 99.2 (4) applications and recommendations of applicants for registration or registration
 99.3 renewal;
 99.4 (5) complaints and recommendations regarding disciplinary matters and proceedings
 99.5 according to sections 214.10; 214.103; and 214.13, subdivisions 6 and 7;
 99.6 (6) approval or creation of a competency exam granting status as an approved
 99.7 education provider; and
 99.8 (7) performance of other duties of advisory councils under chapter 214, or as
 99.9 directed by the board.

99.10 **EFFECTIVE DATE.** This section is effective August 1, 2016.

99.11 Sec. 17. **[148.987] REGISTRATION REQUIREMENTS.**

99.12 Subdivision 1. **Registration.** To be eligible for registration according to sections
 99.13 148.981 to 148.9886, an applicant must:

- 99.14 (1) pay applicable fees;
 99.15 (2) submit to a criminal background check and pay the fees associated with obtaining
 99.16 the criminal background check. The background check shall be conducted in accordance
 99.17 with section 214.075; and
 99.18 (3) file a written application on a form provided by the board that includes:
 99.19 (i) the applicant's name, Social Security number, home address and telephone
 99.20 number, business address and telephone number, and business setting;
 99.21 (ii) proof, as required by the board, of:
 99.22 (A) having obtained a high school diploma or its equivalent;
 99.23 (B) being 18 years of age or older;
 99.24 (C) current cardiopulmonary resuscitation and first aid certification;
 99.25 (D) current professional liability insurance coverage, with a minimum of \$1,000,000
 99.26 of coverage per occurrence; and
 99.27 (E) proof, as required by the board, that the applicant has completed a postsecondary
 99.28 course of study that included a minimum of 500 contact hours of combined massage and
 99.29 bodywork therapy, theory, and practice training consisting of at least:
 99.30 i. 120 combined hours of science, including anatomy and physiology, kinesiology,
 99.31 pathology, hygiene, and standard precautions; and
 99.32 ii. 340 combined clinical and practice hours, including massage and bodywork
 99.33 therapy techniques; supervised practice; professional ethics and standards of practice;
 99.34 business and legal practices related to massage and bodywork therapy; and history, theory,
 99.35 and research related to massage and bodywork therapy;

- 100.1 (iii) unless registered under subdivision 3 or 4, successful completion of a
 100.2 competency exam;
- 100.3 (iv) a list of credentials or memberships held in this state or other states or from
 100.4 private credentialing or professional organizations;
- 100.5 (v) a description of any other state or municipality's refusal to credential the applicant;
- 100.6 (vi) a description of all professional disciplinary actions initiated against the
 100.7 applicant in any jurisdiction;
- 100.8 (vii) any history of drug or alcohol abuse;
- 100.9 (viii) any misdemeanor or felony conviction;
- 100.10 (ix) additional information as requested by the board;
- 100.11 (x) the applicant's signature on a statement that the information in the application is
 100.12 true and correct to the best of the applicant's knowledge; and
- 100.13 (xi) the applicant's signature on a waiver authorizing the board to obtain access to
 100.14 the applicant's records in this state or any other state in which the applicant has engaged in
 100.15 the practice of massage and bodywork therapy.

100.16 **Subd. 2. Registration prohibited.** The board shall deny an application for
 100.17 registration if an applicant:

100.18 (1) has been convicted in this state of any of the following crimes, or of equivalent
 100.19 crimes in another state:

- 100.20 (i) prostitution as defined under section 609.321, 609.324, or 609.3242;
- 100.21 (ii) human trafficking as defined under section 609.282, 609.283, or 609.322;
- 100.22 (iii) criminal sexual conduct under sections 609.342 to 609.3451, or 609.3453; or
- 100.23 (iv) a violent crime as defined under section 611A.08, subdivision 6;

100.24 (2) is a registered sex offender under section 243.166;

100.25 (3) has been subject to disciplinary action under section 146A.09 or similar provision
 100.26 under the laws of another state, if the board determines such a denial is necessary to
 100.27 protect the public; or

100.28 (4) is charged with or under investigation for a complaint in this state or any state
 100.29 that would constitute a violation of statutes or rules established for the practice of massage
 100.30 and bodywork therapy in this state, and the charge or complaint has not been resolved
 100.31 in favor of the applicant.

100.32 **Subd. 3. Registration by endorsement.** (a) To be eligible for registration by
 100.33 endorsement, an applicant shall:

100.34 (1) meet the requirements for registration in subdivision 1, clauses (1), (2), and
 100.35 (3), items (iv) to (xi); and

101.1 (2) provide proof of a current and unrestricted equivalent credential in another
101.2 state that has qualifications at least equivalent to the requirements of sections 148.981 to
101.3 148.9886. The proof shall include records as required by rules of the board.

101.4 (b) Registrations issued by endorsement shall expire on the same schedule and be
101.5 renewed by the same procedures as registrations issued under subdivision 1.

101.6 Subd. 4. **Registration by grandfathering.** (a) To be eligible for registration by
101.7 grandfathering, an applicant shall:

101.8 (1) meet the requirements for registration in subdivision 1, clauses (1), (2), and
101.9 (3), items (iv) to (xi); and

101.10 (2) provide documentation as specified by the board demonstrating the applicant has
101.11 met at least one of the following qualifications:

101.12 (i) successful completion of at least 500 hours of supervised classroom and hands-on
101.13 instruction relating to massage and bodywork therapy;

101.14 (ii) successful completion of a competency exam;

101.15 (iii) evidence of experience in the practice of massage and bodywork therapy for at
101.16 least two of the previous five years immediately preceding application; or

101.17 (iv) active membership in a professional organization for at least two of the previous
101.18 five years immediately preceding application.

101.19 (b) Registrations issued by grandfathering shall expire and be renewed on the same
101.20 schedule and by the same procedures as registrations issued under subdivision 1.

101.21 (c) This subdivision is effective for two years after the first date the board has made
101.22 applications available.

101.23 Subd. 5. **Temporary permit.** A temporary permit to practice as a registered
101.24 massage and bodywork therapist may be issued to an applicant eligible for registration
101.25 under subdivision 1, 3, or 4, if the application for registration is complete, all applicable
101.26 requirements in this section have been met, and applicable fees have been paid. The
101.27 temporary permit remains valid until the board takes action on the applicant's application.

101.28 **EFFECTIVE DATE.** This section is effective August 1, 2016.

101.29 Sec. 18. **[148.9871] EXPIRATION AND RENEWAL.**

101.30 Subdivision 1. **Registration expiration.** Registrations issued according to this
101.31 chapter expire annually.

101.32 Subd. 2. **Renewal.** To be eligible for registration renewal, a registrant must
101.33 annually, or as determined by the board:

101.34 (1) complete a renewal application on a form provided by the board;

101.35 (2) submit applicable fees; and

102.1 (3) submit any additional information requested by the board to clarify information
102.2 presented in the renewal application. The information must be submitted within 30 days
102.3 after the board's request, or the renewal request is canceled.

102.4 Subd. 3. **Change of address.** A registrant who changes addresses must inform
102.5 the board within 30 days, in writing, of the change of address. Notices or other
102.6 correspondence mailed to or served on a registrant at the registrant's current address on
102.7 file shall be considered as having been received by the registrant.

102.8 Subd. 4. **Registration renewal notice.** At least 60 days before the registration
102.9 renewal date, the board shall send out a renewal notice to the last known address of the
102.10 registrant on file. The notice must include a renewal application and a notice of fees
102.11 required for renewal. It must also inform the registrant that registration will expire without
102.12 further action by the board if an application for registration renewal is not received before
102.13 the deadline for renewal. The registrant's failure to receive this notice shall not relieve the
102.14 registrant of the obligation to meet the deadline and other requirements for registration
102.15 renewal. Failure to receive this notice is not grounds for challenging expiration of
102.16 registered status.

102.17 Subd. 5. **Renewal deadline.** The renewal application and fee must be postmarked
102.18 on or before October 1 of the year of renewal or as determined by the board. If the
102.19 postmark is illegible, the application shall be considered timely if received by the third
102.20 working day after the deadline.

102.21 Subd. 6. **Inactive status and return to active status.** (a) A registration may be
102.22 placed in inactive status upon application to the board by the registrant and upon payment
102.23 of an inactive status fee.

102.24 (b) A registrant seeking restoration to active status from inactive status must pay
102.25 the current renewal fees and all unpaid back inactive fees. The registrant must meet
102.26 the criteria for renewal under subdivision 7 prior to submitting an application to regain
102.27 registered status. If the registrant has been in inactive status for more than five years, a
102.28 qualifying score on a competency exam is required.

102.29 Subd. 7. **Registration following lapse of registration status for two years or less.**
102.30 In order for an individual whose registration status has lapsed for two years or less, to
102.31 regain registration status, the individual must:

102.32 (1) apply for registration renewal according to subdivision 2; and

102.33 (2) submit applicable fees for the period not registered, including the fee for late
102.34 renewal.

102.35 Subd. 8. **Cancellation due to nonrenewal.** The board shall not renew, reissue,
102.36 reinstate, or restore a registration that has lapsed and has not been renewed within two

103.1 years. A registrant whose registration is canceled for nonrenewal must obtain a new
103.2 registration by applying for initial registration and fulfilling all requirements then in
103.3 existence for initial registration as a massage and bodywork therapist.

103.4 Subd. 9. **Cancellation of registration in good standing.** (a) A registrant holding
103.5 active registration as a massage and bodywork therapist in this state may, upon approval
103.6 of the board, be granted registration cancellation if the board is not investigating the
103.7 person as a result of a complaint or information received or if the board has not begun
103.8 disciplinary proceedings against the registrant. Such action by the board shall be reported
103.9 as a cancellation of registration in good standing.

103.10 (b) A registrant who receives board approval for registration cancellation is not
103.11 entitled to a refund of any registration fees paid for the registration period in which
103.12 cancellation of the registration occurred.

103.13 (c) To obtain registration after cancellation, an applicant must obtain a new
103.14 registration by applying for initial registration and fulfilling the requirements then in
103.15 existence for obtaining initial registration according to sections 148.981 to 148.9886.

103.16 **EFFECTIVE DATE.** This section is effective August 1, 2016.

103.17 Sec. 19. **[148.9881] BOARD ACTION ON APPLICATIONS.**

103.18 (a) The board shall act on each application for registration or renewal according
103.19 to paragraphs (b) and (d).

103.20 (b) The board or advisory council shall determine if the applicant meets the
103.21 requirements for registration or renewal under section 148.987 or 148.9871. The board
103.22 or advisory council may investigate information provided by an applicant to determine
103.23 whether the information is accurate and complete, and may request additional information
103.24 or documentation.

103.25 (c) The board shall notify each applicant, in writing, of action taken on the
103.26 application, the grounds for denying registration if registration is denied, and the
103.27 applicant's right to review under paragraph (d).

103.28 (d) An applicant denied registration may make a written request to the board, within
103.29 30 days of the board's notice, to appear before the advisory council and for the advisory
103.30 council to review the board's decision to deny the applicant's registration. After reviewing
103.31 the denial, the advisory council shall make a recommendation to the board as to whether
103.32 the denial shall be affirmed. Each applicant is allowed only one request for review per
103.33 registration period.

103.34 **EFFECTIVE DATE.** This section is effective August 1, 2016.

104.1 Sec. 20. [148.9882] GROUNDS FOR DISCIPLINARY ACTION.

104.2 Subdivision 1. Grounds listed. (a) The board may deny, revoke, suspend, limit, or
104.3 condition the registration of a registrant or registered massage and bodywork therapist, or
104.4 may otherwise discipline a registrant. The fact that massage and bodywork therapy may
104.5 be considered a less customary approach to health care shall not constitute the basis for
104.6 disciplinary action per se.

104.7 (b) The following are grounds for disciplinary action, regardless of whether injury
104.8 to a client is established:

104.9 (1) failing to demonstrate the qualifications or to satisfy the requirements for
104.10 registration contained in sections 148.981 to 148.9886, or rules of the board. In the case of
104.11 an applicant, the burden of proof is on the applicant to demonstrate the qualifications or
104.12 satisfy the requirements;

104.13 (2) advertising in a false, fraudulent, deceptive, or misleading manner, including,
104.14 but not limited to:

104.15 (i) advertising or holding oneself out as a "registered massage and bodywork
104.16 therapist" or any abbreviation or derivative thereof to indicate such a title, when such
104.17 registration is not valid or current for any reason;

104.18 (ii) advertising or holding oneself out as a "licensed massage and bodywork
104.19 therapist" or any abbreviation or derivative thereof to indicate such a title, unless the
104.20 registrant currently holds a valid state license in another state and provided that the state
104.21 is clearly identified;

104.22 (iii) advertising a service, the provision of which would constitute a violation of this
104.23 chapter or rules established by the board; and

104.24 (iv) using fraud, deceit, or misrepresentation when communicating with the general
104.25 public, health care providers, or other business professionals;

104.26 (3) falsifying information in a massage and bodywork therapy registration or renewal
104.27 application or attempting to obtain registration, registration renewal, or reinstatement by
104.28 fraud, deception, or misrepresentation, or aiding and abetting any of these acts;

104.29 (4) engaging in conduct with a client that is sexual or may reasonably be interpreted
104.30 by the client as sexual, or in any verbal behavior that is seductive or sexually demeaning
104.31 to a client, or engaging in sexual exploitation of a client, without regard to who initiates
104.32 such behaviors;

104.33 (5) committing an act of gross malpractice, negligence, or incompetency, or failing
104.34 to practice massage and bodywork therapy with the level of care, skill, and treatment
104.35 that is recognized by a reasonably prudent massage and bodywork therapist as being
104.36 acceptable under similar conditions and circumstances;

105.1 (6) having an actual or potential inability to practice massage and bodywork therapy
105.2 with reasonable skill and safety to clients by reason of illness, as a result of any mental
105.3 or physical condition, or use of alcohol, drugs, chemicals, or any other material. Being
105.4 adjudicated as mentally incompetent, mentally ill, a chemically dependent person, or a
105.5 person dangerous to the public by a court of competent jurisdiction, inside or outside
105.6 of this state, may be considered as evidence of an inability to practice massage and
105.7 bodywork therapy;

105.8 (7) being the subject of disciplinary action as a massage and bodywork therapist by
105.9 another state or jurisdiction where the board or advisory council determines that the cause
105.10 of the disciplinary action would be a violation under this state's statutes or rules of the
105.11 board if the violation had occurred in this state;

105.12 (8) failing to notify the board of revocation or suspension of a credential, or any
105.13 other disciplinary action taken by this or any other state, territory, or country, including
105.14 any restrictions on the right to practice; or the surrender or voluntary termination of a
105.15 credential during a board investigation of a complaint, as part of a disciplinary order, or
105.16 while under a disciplinary order;

105.17 (9) conviction of a crime, including a finding or verdict of guilt, an admission of
105.18 guilt, or a no-contest plea, in any court in Minnesota or any other jurisdiction in the
105.19 United States, reasonably related to engaging in massage and bodywork therapy practices.
105.20 Conviction, as used in this clause, includes a conviction of an offense which, if committed
105.21 in this state, would be deemed a felony, gross misdemeanor, or misdemeanor, without
105.22 regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of
105.23 guilty is made or returned but the adjudication of guilt is either withheld or not entered;

105.24 (10) if a registrant is on probation, failing to abide by terms of that probation;

105.25 (11) practicing or offering to practice beyond the scope of the practice of massage
105.26 and bodywork therapy;

105.27 (12) managing client records and information improperly, including, but not limited
105.28 to failing to maintain adequate client records, comply with a client's request made according
105.29 to sections 144.291 to 144.298, or furnish a client record or report required by law;

105.30 (13) revealing a privileged communication from or relating to a client except when
105.31 otherwise required or permitted by law;

105.32 (14) providing massage and bodywork therapy services that are linked to the
105.33 financial gain of a referral source;

105.34 (15) obtaining money, property, or services from a client, other than reasonable
105.35 fees for services provided to the client, through the use of undue influence, harassment,
105.36 duress, deception, or fraud;

106.1 (16) engaging in abusive or fraudulent billing practices, including violations of
106.2 federal Medicare and Medicaid laws or state medical assistance laws;

106.3 (17) failing to consult with a client's health care provider who prescribed a course of
106.4 massage and bodywork therapy treatment if the treatment needs to be altered from the
106.5 original written order to conform with standards in the massage and bodywork therapy
106.6 field or the registrant's level of training or experience;

106.7 (18) failing to cooperate with an investigation of the board or its representatives,
106.8 including failing to respond fully and promptly to any question raised by or on behalf
106.9 of the board relating to the subject of the investigation, failing to execute all releases
106.10 requested by the board, failing to provide copies of client records, as reasonably requested
106.11 by the board to assist in its investigation, and failing to appear at conferences or hearings
106.12 scheduled by the board or its staff;

106.13 (19) interfering with an investigation or disciplinary proceeding, including by willful
106.14 misrepresentation of facts or by the use of threats or harassment to prevent a person from
106.15 providing evidence in a disciplinary proceeding or any legal action;

106.16 (20) violating a statute, rule, order, or agreement for corrective action that the board
106.17 issued or is otherwise authorized or empowered to enforce;

106.18 (21) aiding or abetting a person in violating sections 148.981 to 148.9886;

106.19 (22) failing to report to the board other massage and bodywork therapists who
106.20 commit violations of sections 148.981 to 148.9886; and

106.21 (23) failing to notify the board, in writing, of the entry of a final judgment by a
106.22 court of competent jurisdiction against the registrant for malpractice of massage and
106.23 bodywork therapy, or any settlement by the registrant in response to charges or allegations
106.24 of malpractice of massage and bodywork therapy. The notice must be provided to the
106.25 board within 60 days after the entry of a judgment, and must contain the name of the
106.26 court, case number, and the names of all parties to the action.

106.27 Subd. 2. **Evidence.** In disciplinary actions alleging a violation of subdivision 1,
106.28 a copy of the judgment or proceeding under the seal of the court administrator or of the
106.29 administrative agency that entered the same shall be admissible into evidence without
106.30 further authentication and shall constitute prima facie evidence of the violation.

106.31 Subd. 3. **Examination; access to medical data.** The board may take the actions
106.32 described in section 148.261, subdivision 5, if it has probable cause to believe that
106.33 grounds for disciplinary action exist under subdivision 1, paragraph (b), clause (6). The
106.34 requirements and limitations described in section 148.261, subdivision 5, shall apply.

106.35 **EFFECTIVE DATE.** This section is effective August 1, 2016.

107.1 Sec. 21. **[148.9883] DISCIPLINE; REPORTING.**

107.2 For purposes of sections 148.981 to 148.9886, registered massage and bodywork
107.3 therapists and applicants are subject to sections 148.262 to 148.266.

107.4 **EFFECTIVE DATE.** This section is effective August 1, 2016.

107.5 Sec. 22. **[148.9884] EFFECT ON MUNICIPAL ORDINANCES.**

107.6 Subdivision 1. **License authority.** The provisions of sections 148.981 to 148.9886
107.7 preempt the licensure and regulation of registered massage and bodywork therapists
107.8 by a municipality, including, without limitation, conducting a criminal background
107.9 investigation and examination of a massage and bodywork therapist or applicant for a
107.10 municipality's credential to practice massage and bodywork therapy.

107.11 Subd. 2. **Municipal regulation.** Nothing in sections 148.981 to 148.9886 shall
107.12 be construed to limit a municipality from:

107.13 (1) requiring a massage business establishment to obtain a business license or permit
107.14 in order to transact business in the jurisdiction regardless of whether the massage business
107.15 establishment is operated by a registered or unregistered massage and bodywork therapist;

107.16 (2) enforcing the provisions of health codes related to communicable diseases;

107.17 (3) requiring a criminal background check of any unregistered massage and
107.18 bodywork therapist applying for a license to conduct massage and bodywork therapy
107.19 in the municipality; and

107.20 (4) otherwise regulating massage business establishments by ordinance regardless of
107.21 whether the massage business establishment is operated by a registered or unregistered
107.22 massage and bodywork therapist.

107.23 Subd. 3. **Prosecuting authority.** A municipality may prosecute violations of
107.24 sections 148.981 to 148.9886, a local ordinance, or any other law by a registered or
107.25 unregistered massage and bodywork therapist in its jurisdiction.

107.26 **EFFECTIVE DATE.** This section is effective August 1, 2016.

107.27 Sec. 23. **[148.9885] FEES.**

107.28 Subdivision 1. **Fees.** Fees are as follows:

107.29 (1) initial registration with application fee must not exceed \$285;

107.30 (2) annual registration renewal fee must not exceed \$185;

107.31 (3) duplicate registration certificate, \$15;

107.32 (4) late fee, \$50;

107.33 (5) inactive status and inactive to active status reactivation, \$50;

108.1 (6) temporary permit, \$50; and

108.2 (7) returned check, \$35.

108.3 Subd. 2. **Penalty fee for late renewals.** An application for registration renewal
108.4 submitted after the deadline must be accompanied by a late fee in addition to the required
108.5 fees.

108.6 Subd. 3. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

108.7 Subd. 4. **Deposit.** Fees collected by the board under this section shall be deposited
108.8 into the state government special revenue fund.

108.9 Subd. 5. **Special assessment fee.** A special assessment fee not to exceed \$..... shall
108.10 be assessed annually upon registration renewal until the fee revenue equals the board's
108.11 expenditures for registration activities under sections 148.981 to 148.986.

108.12 **EFFECTIVE DATE.** This section is effective August 1, 2016.

108.13 Sec. 24. **[148.9886] EXCHANGING INFORMATION.**

108.14 The board shall report to the Office of Complementary and Alternative Health
108.15 Practices all revocations or suspensions of registered massage and bodywork therapists.
108.16 Upon request by the Office of Complementary and Alternative Health Practices, the board
108.17 may share all complaint, investigatory, and disciplinary data relating to a previously or
108.18 currently registered massage and bodywork therapist.

108.19 **EFFECTIVE DATE.** This section is effective August 1, 2016.

108.20 **SPOKEN LANGUAGE HEALTH CARE INTERPRETER**

108.21 Sec. 25. **[148.9981] DEFINITIONS.**

108.22 Subdivision 1. **Applicability.** The definitions in this section apply to sections
108.23 148.9981 to 148.9987.

108.24 Subd. 2. **Advisory council.** "Advisory council" means the Spoken Language Health
108.25 Care Interpreter Advisory Council established in section 148.9986.

108.26 Subd. 3. **Code of ethics.** "Code of ethics" means the National Code of Ethics for
108.27 Interpreters in Health Care, as published by the National Council on Interpreting in Health
108.28 Care or its successor, or the International Medical Interpreters Association or its successor.

108.29 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

108.30 Subd. 5. **Common languages.** "Common languages" mean the ten most frequent
108.31 languages without regard to dialect in Minnesota for which interpreters are listed on
108.32 the registry.

109.1 Subd. 6. **Interpreting standards of practice.** "Interpreting standards of practice"
109.2 means the interpreting standards of practice in health care as published by the National
109.3 Council on Interpreting in Health Care or its successor, or the International Medical
109.4 Interpreters Association or its successor.

109.5 Subd. 7. **Registry.** "Registry" means a database of spoken language health
109.6 care interpreters in Minnesota who have met the qualifications described under section
109.7 148.9982, subdivision 2, 3, 4, or 5, which shall be maintained by the commissioner of
109.8 health.

109.9 Subd. 8. **Remote interpretation.** "Remote interpretation" means providing spoken
109.10 language interpreting services via a telephone or by video conferencing.

109.11 Subd. 9. **Spoken language health care interpreter or interpreter.** "Spoken
109.12 language health care interpreter" or "interpreter" means an individual who receives
109.13 compensation or other remuneration for providing spoken language interpreter services for
109.14 patients with limited English proficiency within a medical setting either by face-to-face
109.15 interpretation or remote interpretation.

109.16 Subd. 10. **Spoken language interpreting services.** "Spoken language interpreting
109.17 services" means the conversion of one spoken language into another by an interpreter for
109.18 the purpose of facilitating communication between a patient and a health care provider
109.19 who do not share a common spoken language.

109.20 Sec. 26. **[148.9982] REGISTRY.**

109.21 Subdivision 1. **Establishment.** (a) By July 1, 2017, the commissioner of health
109.22 shall establish and maintain a registry for spoken language health care interpreters. The
109.23 registry shall contain four separate tiers based on different qualification standards for
109.24 education and training.

109.25 (b) An individual who wants to be listed on the registry must submit an application
109.26 to the commissioner on a form provided by the commissioner along with all applicable
109.27 fees required under section 148.9987. The form must include the applicant's name; Social
109.28 Security number; business address and telephone number, or home address and telephone
109.29 number if the applicant has a home office; the applicant's employer or the agencies with
109.30 which the applicant is affiliated; the employer's or agencies' addresses and telephone
109.31 numbers; and the languages the applicant is qualified to interpret.

109.32 (c) Upon receipt of the application, the commissioner shall determine if the applicant
109.33 meets the requirements for the applicable registry tier. The commissioner may request
109.34 further information from the applicant if the information provided is not complete or

110.1 accurate. The commissioner shall notify the applicant of action taken on the application,
110.2 and if the application is denied, the grounds for denying the application.

110.3 (d) If the commissioner denies an application, the applicant may apply for a lower
110.4 tier or may reapply for the same tier at a later date. If an applicant applies for a different
110.5 tier or reapplies for the same tier, the applicant must submit with the new application the
110.6 applicable fees under section 148.9987.

110.7 (e) Applicants who qualify for different tiers for different languages shall only be
110.8 required to complete one application and submit with the application the fee associated
110.9 with the highest tier for which the applicant is applying.

110.10 (f) The commissioner may request, as deemed necessary, additional information
110.11 from an applicant to determine or verify qualifications or collect information to manage
110.12 the registry or monitor the field of health care interpreting.

110.13 Subd. 2. **Tier 1 requirements.** The commissioner shall include on the tier 1 registry
110.14 an applicant who meets the following requirements:

110.15 (1) is at least 18 years of age;

110.16 (2) passes an examination approved by the commissioner on basic medical
110.17 terminology in English;

110.18 (3) passes an examination approved by the commissioner on interpreter ethics and
110.19 standards of practice; and

110.20 (4) affirms by signature, including electronic signature, that the applicant has read
110.21 the code of ethics and interpreting standards of practice identified on the registry Web
110.22 site and agrees to abide by them.

110.23 Subd. 3. **Tier 2 requirements.** The commissioner shall include on the tier 2 registry
110.24 an applicant who meets the requirements for tier 1 described under subdivision 2 and who:

110.25 (1) effective July 1, 2017, to June 30, 2018, provides proof of successfully
110.26 completing a training program for medical interpreters approved by the commissioner that
110.27 is, at a minimum, 40 hours in length; or

110.28 (2) effective July 1, 2018, provides proof of successfully completing a training
110.29 program for medical interpreters approved by the commissioner that is equal in length to
110.30 the number of hours required by the Certification Commission for Healthcare Interpreters
110.31 (CCHI) or National Council on Interpreting in Health Care (NCIHC) or their successors.
110.32 If the number of hours required by CCHI or its successor and the number of hours required
110.33 by the NCIHC or its successor differ, the number of hours required to qualify for the
110.34 registry shall be the greater of the two. A training program of 40 hours or more approved
110.35 by the commissioner and completed prior to July 1, 2017, may count toward the number
110.36 of hours required.

111.1 Subd. 4. **Tier 3 requirements.** The commissioner shall include on the tier 3 registry
111.2 an applicant who meets the requirements for tier 1 described under subdivision 2 and who:

111.3 (1) has a national certification in health care interpreting that does not include a
111.4 performance examination from a certifying organization approved by the commissioner; or

111.5 (2) provides proof of successfully completing an interpreting certification program
111.6 from an accredited United States academic institution approved by the commissioner
111.7 that is, at a minimum, 18 semester credits.

111.8 Subd. 5. **Tier 4 requirements.** (a) The commissioner shall include on the tier 4
111.9 registry an applicant who meets the requirements for tier 1 described under subdivision 2
111.10 and who:

111.11 (1) has a national certification from a certifying organization approved by the
111.12 commissioner in health care interpreting that includes a performance examination in the
111.13 non-English language in which the interpreter is registering to interpret; or

111.14 (2)(i) has an associate's degree or higher in interpreting from an accredited United
111.15 States academic institution. The degree and institution must be approved by the
111.16 commissioner and the degree must include a minimum of three semester credits in medical
111.17 terminology or medical interpreting; and

111.18 (ii) has achieved a score of "advanced mid" or higher on the American Council on
111.19 the Teaching of Foreign Languages Oral Proficiency Interview in a non-English language
111.20 in which the interpreter is registering to interpret.

111.21 (b) The commissioner, in consultation with the advisory council, may approve
111.22 alternative means of meeting oral proficiency requirements for tier 4 for languages
111.23 in which the American Council of Teaching of Foreign Languages Oral Proficiency
111.24 Interview is not available.

111.25 (c) The commissioner, in consultation with the advisory council, may approve a
111.26 degree from an educational institution from a foreign country as meeting the associate's
111.27 degree requirement in paragraph (a), clause (2). The commissioner may assess the
111.28 applicant a fee to cover the cost of foreign credential evaluation services approved by
111.29 the commissioner, in consultation with the advisory council, and any additional steps
111.30 necessary to process the application. Any assessed fee must be paid by the interpreter
111.31 before the interpreter will be registered.

111.32 Subd. 6. **Change of name and address.** Registered spoken language health
111.33 care interpreters who change their name, address, or e-mail address must inform the
111.34 commissioner in writing of the change within 30 days. All notices or other correspondence
111.35 mailed to the interpreter's address or e-mail address on file with the commissioner shall
111.36 be considered as having been received by the interpreter.

112.1 Subd. 7. **Data.** Section 13.41 applies to government data of the commissioner
112.2 on applicants and registered interpreters.

112.3 Sec. 27. **[148.9983] RENEWAL.**

112.4 Subdivision 1. **Registry period.** Listing on the registry is valid for a one-year
112.5 period. To renew inclusion on the registry, an interpreter must submit:

112.6 (1) a renewal application on a form provided by the commissioner;

112.7 (2) a continuing education report on a form provided by the commissioner as
112.8 specified under section 148.9985; and

112.9 (3) the required fees under section 148.9987.

112.10 Subd. 2. **Notice.** (a) Sixty days before the registry expiration date, the commissioner
112.11 shall send out a renewal notice to the spoken language health care interpreter's last known
112.12 address or e-mail address on file with the commissioner. The notice must include an
112.13 application for renewal and the amount of the fee required for renewal. If the interpreter
112.14 does not receive the renewal notice, the interpreter is still required to meet the deadline for
112.15 renewal to qualify for continuous inclusion on the registry.

112.16 (b) An application for renewal must be received by the commissioner or postmarked
112.17 at least 30 calendar days before the registry expiration date.

112.18 Subd. 3. **Late fee.** A renewal application submitted after the renewal deadline
112.19 date must include the late fee specified in section 148.9987. Fees for late renewal shall
112.20 not be prorated.

112.21 Subd. 4. **Lapse in renewal.** An interpreter whose registry listing has been expired
112.22 for a period of one year or longer must submit a new application to be listed on the registry
112.23 instead of a renewal application.

112.24 Sec. 28. **[148.9984] DISCIPLINARY ACTIONS; OVERSIGHT OF**
112.25 **COMPLAINTS.**

112.26 Subdivision 1. **Prohibited conduct.** (a) The following conduct is prohibited and is
112.27 grounds for disciplinary or corrective action:

112.28 (1) failure to provide spoken language interpreting services consistent with the
112.29 code of ethics and interpreting standards of practice, or performance of the interpretation
112.30 in an incompetent or negligent manner;

112.31 (2) conviction of a crime, including a finding or verdict of guilt, an admission of
112.32 guilt, or a no-contest plea, in any court in Minnesota or any other jurisdiction in the United
112.33 States, demonstrably related to engaging in spoken language health care interpreter

113.1 services. Conviction includes a conviction for an offense which, if committed in this
113.2 state, would be deemed a felony;

113.3 (3) conviction of violating any state or federal law, rule, or regulation that directly
113.4 relates to the practice of spoken language health care interpreters;

113.5 (4) adjudication as mentally incompetent or as a person who is dangerous to self
113.6 or adjudication pursuant to chapter 253B as chemically dependent, developmentally
113.7 disabled, mentally ill and dangerous to the public, or as a sexual psychopathic personality
113.8 or sexually dangerous person;

113.9 (5) violation or failure to comply with an order issued by the commissioner;

113.10 (6) obtaining money, property, services, or business from a client through the use of
113.11 undue influence, excessive pressure, harassment, duress, deception, or fraud;

113.12 (7) revocation of the interpreter's national certification as a result of disciplinary
113.13 action brought by the national certifying body;

113.14 (8) failure to perform services with reasonable judgment, skill, or safety due to the
113.15 use of alcohol or drugs or other physical or mental impairment;

113.16 (9) engaging in conduct likely to deceive, defraud, or harm the public;

113.17 (10) demonstrating a willful or careless disregard for the health, welfare, or safety
113.18 of a client;

113.19 (11) failure to cooperate with the commissioner or advisory council in an
113.20 investigation or to provide information in response to a request from the commissioner
113.21 or advisory council;

113.22 (12) aiding or abetting another person in violating any provision of sections
113.23 148.9981 to 148.9987; and

113.24 (13) release or disclosure of a health record in violation of sections 144.291 to
113.25 144.298.

113.26 (b) In disciplinary actions alleging a violation of paragraph (a), clause (2), (3), or
113.27 (4), a copy of the judgment or proceeding under seal of the court administrator, or of the
113.28 administrative agency that entered the same, is admissible into evidence without further
113.29 authentication and constitutes prima facie evidence of its contents.

113.30 Subd. 2. **Complaints.** The commissioner may initiate an investigation upon
113.31 receiving a complaint or other oral or written communication that alleges or implies
113.32 a violation of subdivision 1. In the receipt, investigation, and hearing of a complaint
113.33 that alleges or implies a violation of subdivision 1, the commissioner shall follow the
113.34 procedures in section 214.10.

114.1 Subd. 3. **Disciplinary actions.** If the commissioner finds that an interpreter who
114.2 is listed on the registry has violated any provision of sections 148.9981 to 148.9987, the
114.3 commissioner may take any one or more of the following actions:

114.4 (1) remove the interpreter from the registry;

114.5 (2) impose limitations or conditions on the interpreter's practice, impose
114.6 rehabilitation requirements, or require practice under supervision; or

114.7 (3) censure or reprimand the interpreter.

114.8 Subd. 4. **Reinstatement requirements after disciplinary action.** Interpreters
114.9 who have been removed from the registry may request and provide justification for
114.10 reinstatement. The requirements of sections 148.9981 to 148.9987 for registry renewal
114.11 and any other conditions imposed by the commissioner must be met before the interpreter
114.12 may be reinstated on the registry.

114.13 Sec. 29. **[148.9985] CONTINUING EDUCATION.**

114.14 Subdivision 1. **Course approval.** The advisory council shall approve continuing
114.15 education courses and training. A course that has not been approved by the advisory
114.16 council may be submitted, but may be disapproved by the commissioner. If the course
114.17 is disapproved, it shall not count toward the continuing education requirement. The
114.18 interpreter must complete the following hours of continuing education during each
114.19 one-year registry period:

114.20 (1) for tier 2 interpreters, a minimum of four contact hours of continuing education;

114.21 (2) for tier 3 interpreters, a minimum of six contact hours of continuing education; and

114.22 (3) for tier 4 interpreters, a minimum of eight contact hours of continuing education.

114.23 Contact hours shall be prorated for interpreters who are assigned a registry cycle of
114.24 less than one year.

114.25 Subd. 2. **Continuing education verification.** Each spoken language health care
114.26 interpreter shall submit with a renewal application a continuing education report on a form
114.27 provided by the commissioner that indicates that the interpreter has met the continuing
114.28 education requirements of this section. The form shall include the following information:

114.29 (1) the title of the continuing education activity;

114.30 (2) a brief description of the activity;

114.31 (3) the sponsor, presenter, or author;

114.32 (4) the location and attendance dates;

114.33 (5) the number of contact hours; and

114.34 (6) the interpreter's notarized affirmation that the information is true and correct.

115.1 Subd. 3. **Audit.** The commissioner or advisory council may audit a percentage of
115.2 the continuing education reports based on a random selection.

115.3 Sec. 30. **[148.9986] SPOKEN LANGUAGE HEALTH CARE INTERPRETER**
115.4 **ADVISORY COUNCIL.**

115.5 Subdivision 1. **Establishment.** The commissioner shall appoint 12 members to a
115.6 Spoken Language Health Care Interpreter Advisory Council consisting of the following
115.7 members:

115.8 (1) three members who are interpreters listed on the roster prior to July 1, 2017, or
115.9 on the registry after July 1, 2017, and who are Minnesota residents. Of these members,
115.10 each must be an interpreter for a different language; at least one must have a national
115.11 certification credential; and at least one must have been listed on the roster prior to July 1,
115.12 2017, or on the registry after July 1, 2017, as an interpreter in a language other than the
115.13 common languages and must have completed a training program for medical interpreters
115.14 approved by the commissioner that is, at a minimum, 40 hours in length;

115.15 (2) three members representing limited English proficient (LEP) individuals, of
115.16 these members, two must represent LEP individuals who are proficient in a common
115.17 language and one must represent LEP individuals who are proficient in a language that is
115.18 not one of the common languages;

115.19 (3) one member representing a health plan company;

115.20 (4) one member representing a Minnesota health system who is not an interpreter;

115.21 (5) one member representing an interpreter agency;

115.22 (6) one member representing an interpreter training program or postsecondary
115.23 educational institution program providing interpreter courses or skills assessment;

115.24 (7) one member who is affiliated with a Minnesota-based or Minnesota chapter of a
115.25 national or international organization representing interpreters; and

115.26 (8) one member who is a licensed direct care health provider.

115.27 Subd. 2. **Organization.** The advisory council shall be organized and administered
115.28 under section 15.059.

115.29 Subd. 3. **Duties.** The advisory council shall:

115.30 (1) advise the commissioner on issues relating to interpreting skills, ethics, and
115.31 standards of practice, including reviewing and recommending changes to the examinations
115.32 identified in section 148.9982, subdivision 2, on basic medical terminology in English
115.33 and interpreter ethics and interpreter standards of practice;

- 116.1 (2) advise the commissioner on recommended changes to accepted spoken language
116.2 health care interpreter qualifications, including degree and training programs and
116.3 performance examinations;
- 116.4 (3) address barriers for interpreters to gain access to the registry, including barriers
116.5 to interpreters of uncommon languages and interpreters in rural areas;
- 116.6 (4) advise the commissioner on methods for identifying gaps in interpreter services in
116.7 rural areas and make recommendations to address interpreter training and funding needs;
- 116.8 (5) inform the commissioner on emerging issues in the spoken language health
116.9 care interpreter field;
- 116.10 (6) advise the commissioner on training and continuing education programs;
- 116.11 (7) provide for distribution of information regarding interpreter standards and
116.12 resources to help interpreters qualify for higher registry tier levels;
- 116.13 (8) make recommendations for necessary statutory changes to Minnesota interpreter
116.14 law;
- 116.15 (9) compare the annual cost of administering the registry and the annual total
116.16 collection of registration fees and advise the commissioner, if necessary, to recommend an
116.17 adjustment to the registration fees;
- 116.18 (10) identify barriers to meeting tier requirements and make recommendations to the
116.19 commissioner for addressing these barriers;
- 116.20 (11) identify and make recommendations to the commissioner for Web distribution
116.21 of patient and provider education materials on working with an interpreter and on reporting
116.22 interpreter behavior as identified in section 148.9984; and
- 116.23 (12) review and update as necessary the process for determining common languages.

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

116.25 Sec. 31. **[148.9987] FEES.**

116.26 **Subdivision 1. Fees.** (a) The initial and renewal application fees for interpreters
116.27 listed on the registry shall be established by the commissioner not to exceed \$90.

116.28 (b) The renewal late fee for the registry shall be established by the commissioner
116.29 not to exceed \$30.

116.30 (c) If the commissioner must translate a document to verify whether a foreign degree
116.31 qualifies for registration for tier 4, the commissioner may assess a fee equal to the actual
116.32 cost of translation and additional effort necessary to process the application.

116.33 **Subd. 2. Nonrefundable fees.** The fees in this section are nonrefundable.

116.34 **Subd. 3. Deposit.** Fees received under sections 148.9981 to 148.9987 shall be
116.35 deposited in the state government special revenue fund.

117.1 Sec. 32. Minnesota Statutes 2015 Supplement, section 256B.0625, subdivision 18a,
117.2 is amended to read:

117.3 Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for
117.4 meals for persons traveling to receive medical care may not exceed \$5.50 for breakfast,
117.5 \$6.50 for lunch, or \$8 for dinner.

117.6 (b) Medical assistance reimbursement for lodging for persons traveling to receive
117.7 medical care may not exceed \$50 per day unless prior authorized by the local agency.

117.8 (c) Regardless of the number of employees that an enrolled health care provider may
117.9 have, medical assistance covers sign and ~~oral~~ spoken language health care interpreter
117.10 services when provided by an enrolled health care provider during the course of providing
117.11 a direct, person-to-person covered health care service to an enrolled recipient with limited
117.12 English proficiency or who has a hearing loss and uses interpreting services. Coverage
117.13 for ~~face-to-face oral language~~ spoken language health care interpreter services shall be
117.14 provided only if the ~~oral language~~ spoken language health care interpreter used by the
117.15 enrolled health care provider is listed ~~in~~ on the ~~registry~~ or roster established under section
117.16 144.058 or the registry established under sections 148.9981 to 148.9987. Beginning July
117.17 1, 2018, coverage for spoken language health care interpreter services shall be provided
117.18 only if the spoken language health care interpreter used by the enrolled health care
117.19 provider is listed on the registry established under sections 148.9981 to 148.9987.

117.20 Sec. 33. **STRATIFIED MEDICAL ASSISTANCE REIMBURSEMENT SYSTEM**
117.21 **FOR SPOKEN LANGUAGE HEALTH CARE INTERPRETERS.**

117.22 (a) The commissioner of human services, in consultation with the commissioner
117.23 of health, the Spoken Language Health Care Interpreter Advisory Council established
117.24 under Minnesota Statutes, section 148.9986, and representatives from the interpreting
117.25 stakeholder community at large, shall study and make recommendations for creating a
117.26 tiered reimbursement system for the Minnesota public health care programs for spoken
117.27 language health care interpreters based on the different tiers of the spoken language health
117.28 care interpreters registry established by the commissioner of health under Minnesota
117.29 Statutes, sections 148.9981 to 148.9987.

117.30 (b) The commissioner of human services shall submit the proposed reimbursement
117.31 system, including the fiscal costs for the proposed system to the chairs and ranking
117.32 minority members of the house of representatives and senate committees with jurisdiction
117.33 over health and human services policy and finance by January 15, 2017.

117.34 (c) The commissioner of health, in consultation with the Spoken Language Health
117.35 Care Interpreter Advisory Council, shall review the fees established under Minnesota

118.1 Statutes, section 148.9987, and make recommendations based on the results of the
118.2 study and recommendations under paragraph (a) whether the fees are established at an
118.3 appropriate level, including whether specific fees should be established for each tier of the
118.4 registry instead of one uniform fee for all tiers. The total fees collected must be sufficient
118.5 to recover the costs of the spoken language health care registry. If the commissioner
118.6 recommends different fees for the tier, the commissioner shall submit the proposed fees to
118.7 the chairs and ranking minority members of the legislative committees with jurisdiction
118.8 over health and human services policy and finance by January 15, 2018.

118.9 Sec. 34. **INITIAL SPOKEN LANGUAGE HEALTH CARE ADVISORY**
118.10 **COUNCIL MEETING.**

118.11 The commissioner of health shall convene the first meeting of the Spoken Language
118.12 Health Care Advisory Council by October 1, 2016.

118.13 Sec. 35. **SPOKEN LANGUAGE HEALTH CARE INTERPRETER REGISTRY**
118.14 **FEES.**

118.15 Notwithstanding Minnesota Statutes, section 148.9987, paragraph (a), the initial and
118.16 renewal fees for interpreters listed on the spoken language health care registry shall be \$50
118.17 between the period of July 1, 2017, through June 30, 2018, and shall be \$70 between the
118.18 period of July 1, 2018, through June 30, 2019. Beginning July 1, 2019, the fees shall be
118.19 in accordance with Minnesota Statutes, section 148.9987.

118.20 Sec. 36. **APPROPRIATION.**

118.21 \$357,000 in fiscal year 2017 is appropriated from the state government special
118.22 revenue fund to the commissioner of health for the spoken language health care interpreter
118.23 registry. This amount includes \$280,000 for onetime start-up costs for the registry that
118.24 is available until June 30, 2019. The base for this appropriation is \$241,000 in fiscal
118.25 year 2018 and \$156,000 in fiscal year 2019.

118.26 \$25,000 in fiscal year 2017 is appropriated from the state government special revenue
118.27 fund to the commissioner of human services to study and submit a proposed stratified
118.28 medical assistance reimbursement system for spoken language health care interpreters.

118.29 Sec. 37. **REPEALER.**

118.30 Minnesota Statutes 2014, section 144.058, is repealed effective July 1, 2018.

118.31 **MINNESOTA ORTHOTIST, PROSTHETIST, AND PEDORTHIST**
118.32 **PRACTICE ACT**

119.1 Sec. 38. **[153B.10] SHORT TITLE.**

119.2 Chapter 153B may be cited as the "Minnesota Orthotist, Prosthetist, and Pedorthist
119.3 Practice Act."

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

119.5 Sec. 39. **[153B.15] DEFINITIONS.**

119.6 Subdivision 1. **Application.** For purposes of this act, the following words have
119.7 the meanings given.

119.8 Subd. 2. **Advisory council.** "Advisory council" means the Orthotics, Prosthetics,
119.9 and Pedorthics Advisory Council established under section 153B.25.

119.10 Subd. 3. **Board.** "Board" means the Board of Podiatric Medicine.

119.11 Subd. 4. **Custom-fabricated device.** "Custom-fabricated device" means an orthosis,
119.12 prosthesis, or pedorthic device for use by a patient that is fabricated to comprehensive
119.13 measurements or a mold or patient model in accordance with a prescription and which
119.14 requires on-site or in-person clinical and technical judgment in its design, fabrication,
119.15 and fitting.

119.16 Subd. 5. **Licensed orthotic-prosthetic assistant.** "Licensed orthotic-prosthetic
119.17 assistant" or "assistant" means a person, licensed by the board, who is educated and
119.18 trained to participate in comprehensive orthotic and prosthetic care while under the
119.19 supervision of a licensed orthotist or licensed prosthetist. Assistants may perform orthotic
119.20 and prosthetic procedures and related tasks in the management of patient care. The
119.21 assistant may fabricate, repair, and maintain orthoses and prostheses. The use of the title
119.22 "orthotic-prosthetic assistant" or representations to the public is limited to a person who is
119.23 licensed under this chapter as an orthotic-prosthetic assistant.

119.24 Subd. 6. **Licensed orthotic fitter.** "Licensed orthotic fitter" or "fitter" means a
119.25 person licensed by the board who is educated and trained in providing certain orthoses,
119.26 and is trained to conduct patient assessments, formulate treatment plans, implement
119.27 treatment plans, perform follow-up, and practice management pursuant to a prescription.
119.28 An orthotic fitter must be competent to fit certain custom-fitted, prefabricated, and
119.29 off-the-shelf orthoses as follows:

119.30 (1) cervical orthoses, except those used to treat an unstable cervical condition;

119.31 (2) prefabricated orthoses for the upper and lower extremities, except those used in:

119.32 (i) the initial or acute treatment of long bone fractures and dislocations;

119.33 (ii) therapeutic shoes and inserts needed as a result of diabetes; and

119.34 (iii) functional electrical stimulation orthoses;

120.1 (3) prefabricated spinal orthoses, except those used in the treatment of scoliosis or
120.2 unstable spinal conditions, including halo cervical orthoses; and
120.3 (4) trusses.

120.4 The use of the title "orthotic fitter" or representations to the public is limited to a person
120.5 who is licensed under this chapter as an orthotic fitter.

120.6 Subd. 7. **Licensed orthotist.** "Licensed orthotist" means a person licensed by
120.7 the board who is educated and trained to practice orthotics, which includes managing
120.8 comprehensive orthotic patient care pursuant to a prescription. The use of the title
120.9 "orthotist" or representations to the public is limited to a person who is licensed under
120.10 this chapter as an orthotist.

120.11 Subd. 8. **Licensed pedorthist.** "Licensed pedorthist" means a person licensed by
120.12 the board who is educated and trained to manage comprehensive pedorthic patient care
120.13 and who performs patient assessments, formulates and implements treatment plans, and
120.14 performs follow-up and practice management pursuant to a prescription. A pedorthist may
120.15 fit, fabricate, adjust, or modify devices within the scope of the pedorthist's education and
120.16 training. Use of the title "pedorthist" or representations to the public is limited to a person
120.17 who is licensed under this chapter as a pedorthist.

120.18 Subd. 9. **Licensed prosthetist.** "Licensed prosthetist" means a person licensed by
120.19 the board who is educated and trained to manage comprehensive prosthetic patient care,
120.20 and who performs patient assessments, formulates and implements treatment plans, and
120.21 performs follow-up and practice management pursuant to a prescription. Use of the title
120.22 "prosthetist" or representations to the public is limited to a person who is licensed under
120.23 this chapter as a prosthetist.

120.24 Subd. 10. **Licensed prosthetist orthotist.** "Licensed prosthetist orthotist" means a
120.25 person licensed by the board who is educated and trained to manage comprehensive
120.26 prosthetic and orthotic patient care, and who performs patient assessments, formulates and
120.27 implements treatment plans, and performs follow-up and practice management pursuant to
120.28 a prescription. Use of the title "prosthetist orthotist" or representations to the public is
120.29 limited to a person who is licensed under this chapter as a prosthetist orthotist.

120.30 Subd. 11. **NCOPE.** "NCOPE" means National Commission on Orthotic and
120.31 Prosthetic Education, an accreditation program that ensures educational institutions and
120.32 residency programs meet the minimum standards of quality to prepare individuals to enter
120.33 the orthotic, prosthetic, and pedorthic professions.

120.34 Subd. 12. **Orthosis.** "Orthosis" means an external device that is custom-fabricated
120.35 or custom-fitted to a specific patient based on the patient's unique physical condition and
120.36 is applied to a part of the body to help correct a deformity, provide support and protection,

121.1 restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or
121.2 postoperative condition.

121.3 Subd. 13. **Orthotics.** "Orthotics" means the science and practice of evaluating,
121.4 measuring, designing, fabricating, assembling, fitting, adjusting, or servicing an orthosis
121.5 pursuant to a prescription. The practice of orthotics includes providing the initial training
121.6 necessary for fitting an orthotic device for the support, correction, or alleviation of
121.7 neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity.

121.8 Subd. 14. **Over-the-counter.** "Over-the-counter" means a prefabricated,
121.9 mass-produced item that is prepackaged, requires no professional advice or judgment in
121.10 size selection or use, and is currently available at retail stores without a prescription.
121.11 Over-the-counter items are not regulated by this act.

121.12 Subd. 15. **Off-the-shelf.** "Off-the-shelf" means a prefabricated device sized or
121.13 modified for the patient's use pursuant to a prescription and which requires changes to be
121.14 made by a qualified practitioner to achieve an individual fit, such as requiring the item
121.15 to be trimmed, bent, or molded with or without heat, or requiring any other alterations
121.16 beyond self adjustment.

121.17 Subd. 16. **Pedorthic device.** "Pedorthic device" means below-the-ankle partial
121.18 foot prostheses for transmetatarsal and more distal amputations, foot orthoses, and
121.19 subtalar-control foot orthoses to control the range of motion of the subtalar joint.
121.20 A prescription is required for any pedorthic device, modification, or prefabricated
121.21 below-the-knee orthosis addressing a medical condition that originates at the ankle or
121.22 below. Pedorthic devices do not include nontherapeutic inlays or footwear regardless
121.23 of method of manufacture; unmodified, nontherapeutic over-the-counter shoes; or
121.24 prefabricated foot care products.

121.25 Subd. 17. **Pedorthics.** "Pedorthics" means the science and practice of evaluating,
121.26 measuring, designing, fabricating, assembling, fitting, adjusting, or servicing a pedorthic
121.27 device pursuant to a prescription for the correction or alleviation of neuromuscular or
121.28 musculoskeletal dysfunction, disease, injury, or deformity. The practice of pedorthics
121.29 includes providing patient care and services pursuant to a prescription to prevent or
121.30 ameliorate painful or disabling conditions of the foot and ankle.

121.31 Subd. 18. **Prescription.** "Prescription" means an order deemed medically necessary
121.32 by a physician, podiatric physician, osteopathic physician, or a licensed health care
121.33 provider who has authority in this state to prescribe orthotic and prosthetic devices,
121.34 supplies, and services.

121.35 Subd. 19. **Prosthesis.** "Prosthesis" means a custom-designed, fabricated, fitted, or
121.36 modified device to treat partial or total limb loss for purposes of restoring physiological

122.1 function or cosmesis. Prosthesis does not include artificial eyes, ears, fingers, or toes;
 122.2 dental appliances; external breast prosthesis; or cosmetic devices that do not have a
 122.3 significant impact on the musculoskeletal functions of the body.

122.4 Subd. 20. **Prosthetics.** "Prosthetics" means the science and practice of evaluating,
 122.5 measuring, designing, fabricating, assembling, fitting, adjusting, or servicing a prosthesis
 122.6 pursuant to a prescription. It includes providing the initial training necessary to fit a
 122.7 prosthesis in order to replace external parts of a human body lost due to amputation,
 122.8 congenital deformities, or absence.

122.9 Subd. 21. **Resident.** "Resident" means a person who has completed a
 122.10 NCOPE-approved education program in orthotics or prosthetics and is receiving clinical
 122.11 training in a residency accredited by NCOPE.

122.12 Subd. 22. **Residency.** "Residency" means a minimum of an NCOPE-approved
 122.13 program to acquire practical clinical training in orthotics and prosthetics in a patient
 122.14 care setting.

122.15 Subd. 23. **Supervisor.** "Supervisor" means the licensed orthotist, prosthetist, or
 122.16 pedorthist who oversees and is responsible for the delivery of appropriate, effective,
 122.17 ethical, and safe orthotic, prosthetic, or pedorthic patient care.

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

122.19 Sec. 40. **[153B.20] EXCEPTIONS.**

122.20 Nothing in this chapter shall prohibit:

122.21 (1) a physician, osteopathic physician, or podiatric physician licensed by the state of
 122.22 Minnesota from providing services within the physician's scope of practice;

122.23 (2) a professional regulated in this state, including but not limited to physical
 122.24 therapists and occupational therapists, from providing services within the professional's
 122.25 scope of practice;

122.26 (3) the practice of orthotics, prosthetics, or pedorthics by a person who is employed
 122.27 by the federal government or any bureau, division, or agency of the federal government
 122.28 while in the discharge of the employee's official duties;

122.29 (4) the practice of orthotics, prosthetics, or pedorthics by:

122.30 (i) a student enrolled in an accredited or approved orthotics, prosthetics, or
 122.31 pedorthics education program who is performing activities required by the program;

122.32 (ii) a resident enrolled in an NCOPE-accredited residency program; or

122.33 (iii) a person working in a qualified, supervised work experience or internship who
 122.34 is obtaining the clinical experience necessary for licensure under this chapter; or

123.1 (5) an orthotist, prosthetist, prosthetist orthotist, pedorthist, assistant, or fitter who is
123.2 licensed in another state or territory of the United States or in another country that has
123.3 equivalent licensure requirements as approved by the board from providing services within
123.4 the professional's scope of practice subject to this paragraph, if the individual is qualified
123.5 and has applied for licensure under this chapter. The individual shall be allowed to practice
123.6 for no longer than six months following the filing of the application for licensure, unless
123.7 the individual withdraws the application for licensure or the board denies the license.

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

123.9 Sec. 41. **[153B.25] ORTHOTICS, PROSTHETICS, AND PEDORTHICS**
123.10 **ADVISORY COUNCIL.**

123.11 **Subdivision 1. Creation; membership.** (a) There is established an Orthotics,
123.12 Prosthetics, and Pedorthics Advisory Council which shall consist of seven voting members
123.13 appointed by the board. Five members shall be licensed and practicing orthotists,
123.14 prosthetists, or pedorthists. Each profession shall be represented on the advisory council.
123.15 One member shall be a Minnesota-licensed doctor of podiatric medicine who is also a
123.16 member of the Board of Podiatric Medicine, and one member shall be a public member.

123.17 (b) The council shall be organized and administered under section 15.059.

123.18 **Subd. 2. Duties.** The advisory council shall:

123.19 (1) advise the board on enforcement of the provisions contained in this chapter;

123.20 (2) review reports of investigations or complaints relating to individuals and make
123.21 recommendations to the board as to whether a license should be denied or disciplinary
123.22 action taken against an individual;

123.23 (3) advise the board regarding standards for licensure of professionals under this
123.24 chapter; and

123.25 (4) perform other duties authorized for advisory councils by chapter 214, as directed
123.26 by the board.

123.27 **Subd. 3. Chair.** The council must elect a chair from among its members.

123.28 **Subd. 4. Administrative provisions.** The Board of Podiatric Medicine must
123.29 provide meeting space and administrative services for the council.

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

123.31 Sec. 42. **[153B.30] LICENSURE.**

124.1 Subdivision 1. **Application.** An application for a license shall be submitted to the
124.2 board in the format required by the board and shall be accompanied by the required fee,
124.3 which is nonrefundable.

124.4 Subd. 2. **Qualifications.** (a) To be eligible for licensure as an orthotist, prosthetist,
124.5 or prosthetist orthotist, an applicant shall meet orthotist, prosthetist, or prosthetist orthotist
124.6 certification requirements of either the American Board for Certification in Orthotics,
124.7 Prosthetics, and Pedorthics or the Board of Certification/Accreditation requirements in
124.8 effect at the time of the individual's application for licensure and be in good standing
124.9 with the certifying board.

124.10 (b) To be eligible for licensure as a pedorthist, an applicant shall meet the pedorthist
124.11 certification requirements of either the American Board for Certification in Orthotics,
124.12 Prosthetics, and Pedorthics or the Board of Certification/Accreditation that are in effect
124.13 at the time of the individual's application for licensure and be in good standing with
124.14 the certifying board.

124.15 (c) To be eligible for licensure as an orthotic or prosthetic assistant, an applicant shall
124.16 meet the orthotic or prosthetic assistant certification requirements of the American Board
124.17 for Certification in Orthotics, Prosthetics, and Pedorthics that are in effect at the time of
124.18 the individual's application for licensure and be in good standing with the certifying board.

124.19 (d) To be eligible for licensure as an orthotic fitter, an applicant shall meet the
124.20 orthotic fitter certification requirements of either the American Board for Certification in
124.21 Orthotics, Prosthetics, and Pedorthics or the Board of Certification/Accreditation that are
124.22 in effect at the time of the individual's application for licensure and be in good standing
124.23 with the certifying board.

124.24 Subd. 3. **License term.** A license to practice is valid for a term of up to 24 months
124.25 beginning on January 1 or commencing after initially fulfilling the license requirements
124.26 and ending on December 31 of the following year.

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

124.28 Sec. 43. **[153B.35] EMPLOYMENT BY AN ACCREDITED FACILITY; SCOPE**
124.29 **OF PRACTICE.**

124.30 A licensed orthotist, prosthetist, pedorthist, assistant, or orthotic fitter may provide
124.31 limited, supervised patient care services beyond their licensed scope of practice if all of
124.32 the following conditions are met:

124.33 (1) the licensee is employed by a patient care facility that is accredited by a national
124.34 accrediting organization in orthotics, prosthetics, and pedorthics;

125.1 (2) written objective criteria are documented by the accredited facility to describe
125.2 the knowledge and skills required by the licensee to demonstrate competency to provide
125.3 additional specific and limited patient care services that are outside the licensee's scope of
125.4 practice;

125.5 (3) the licensee provides patient care only at the direction of a supervisor who is
125.6 licensed as an orthotist, pedorthist, or prosthetist who is employed by the facility to provide
125.7 the specific patient care or services that are outside the licensee's scope of practice; and

125.8 (4) the supervised patient care occurs in compliance with facility accreditation
125.9 standards.

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

125.11 Sec. 44. **[153B.40] CONTINUING EDUCATION.**

125.12 Subdivision 1. **Requirement.** Each licensee shall obtain the number of continuing
125.13 education hours required by the certifying board to maintain certification status pursuant
125.14 to the specific license category.

125.15 Subd. 2. **Proof of attendance.** A licensee must submit to the board proof of
125.16 attendance at approved continuing education programs during the license renewal period
125.17 in which it was attended in the form of a certificate, statement of continuing education
125.18 credits from the American Board for Certification in Orthotics, Prosthetics, and Pedorthics
125.19 or the Board of Certification/Accreditation, descriptive receipt, or affidavit. The board
125.20 may conduct random audits.

125.21 Subd. 3. **Extension of continuing education requirements.** For good cause, a
125.22 licensee may apply to the board for a six-month extension of the deadline for obtaining
125.23 the required number of continuing education credits. No more than two consecutive
125.24 extensions may be granted. For purposes of this subdivision, "good cause" includes
125.25 unforeseen hardships such as illness, family emergency, or military call-up.

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

125.27 Sec. 45. **[153B.45] LICENSE RENEWAL.**

125.28 Subdivision 1. **Submission of license renewal application.** A licensee must submit
125.29 to the board a license renewal application on a form provided by the board together with
125.30 the license renewal fee. The completed form must be postmarked no later than January 1
125.31 in the year of renewal. The form must be signed by the licensee in the place provided for
125.32 the renewal applicant's signature, include evidence of participation in approved continuing
125.33 education programs, and any other information as the board may reasonably require.

126.1 Subd. 2. **Renewal application postmarked after January 1.** A renewal application
126.2 postmarked after January 1 in the renewal year shall be returned to the licensee for addition
126.3 of the late renewal fee. A license renewal application postmarked after January 1 in the
126.4 renewal year is not complete until the late renewal fee has been received by the board.

126.5 Subd. 3. **Failure to submit renewal application.** (a) At any time after January 1 of
126.6 the applicable renewal year, the board shall send notice to a licensee who has failed to
126.7 apply for license renewal. The notice shall be mailed to the licensee at the last address on
126.8 file with the board and shall include the following information:

126.9 (1) that the licensee has failed to submit application for license renewal;

126.10 (2) the amount of renewal and late fees;

126.11 (3) information about continuing education that must be submitted in order for
126.12 the license to be renewed;

126.13 (4) that the licensee must respond within 30 calendar days after the notice was sent
126.14 by the board; and

126.15 (5) that the licensee may voluntarily terminate the license by notifying the board
126.16 or may apply for license renewal by sending the board a completed renewal application,
126.17 license renewal and late fees, and evidence of compliance with continuing education
126.18 requirements.

126.19 (b) Failure by the licensee to notify the board of the licensee's intent to voluntarily
126.20 terminate the license or to submit a license renewal application shall result in expiration
126.21 of the license and termination of the right to practice. The expiration of the license and
126.22 termination of the right to practice shall not be considered disciplinary action against the
126.23 licensee.

126.24 (c) A license that has been expired under this subdivision may be reinstated.

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

126.26 Sec. 46. **[153B.50] NAME AND ADDRESS CHANGE.**

126.27 (a) A licensee who has changed names must notify the board in writing within 90
126.28 days and request a revised license. The board may require official documentation of the
126.29 legal name change.

126.30 (b) A licensee must maintain with the board a correct mailing address to receive
126.31 board communications and notices. A licensee who has changed addresses must notify the
126.32 board in writing within 90 days. Mailing a notice by United States mail to a licensee's last
126.33 known mailing address constitutes valid mailing.

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

127.1 Sec. 47. **[153B.55] INACTIVE STATUS.**

127.2 (a) A licensee who notifies the board in the format required by the board may elect
127.3 to place the licensee's credential on inactive status and shall be excused from payment
127.4 of renewal fees until the licensee notifies the board in the format required by the board
127.5 of the licensee's plan to return to practice.

127.6 (b) A person requesting restoration from inactive status shall be required to pay the
127.7 current renewal fee and comply with section 153B.45.

127.8 (c) A person whose license has been placed on inactive status shall not practice in
127.9 this state.

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

127.11 Sec. 48. **[153B.60] LICENSE LAPSE DUE TO MILITARY SERVICE.**

127.12 A licensee whose license has expired while on active duty in the armed forces of the
127.13 United States, with the National Guard while called into service or training, or while in
127.14 training or education preliminary to induction into military service may have the licensee's
127.15 license renewed or restored without paying a late fee or license restoration fee if the licensee
127.16 provides verification to the board within two years of the termination of service obligation.

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

127.18 Sec. 49. **[153B.65] ENDORSEMENT.**

127.19 The board may license, without examination and on payment of the required fee,
127.20 an applicant who is an orthotist, prosthetist, prosthetist orthotist, pedorthist, assistant, or
127.21 fitter who is certified by the American Board for Certification in Orthotics, Prosthetics,
127.22 and Pedorthics or a national certification organization with educational, experiential, and
127.23 testing standards equal to or higher than the licensing requirements in Minnesota.

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

127.25 Sec. 50. **[153B.70] GROUNDS FOR DISCIPLINARY ACTION.**

127.26 (a) The board may refuse to issue or renew a license, revoke or suspend a license, or
127.27 place on probation or reprimand a licensee for one or any combination of the following:

127.28 (1) making a material misstatement in furnishing information to the board;

127.29 (2) violating or intentionally disregarding the requirements of this chapter;

127.30 (3) conviction of a crime, including a finding or verdict of guilt, an admission of
127.31 guilt, or a no-contest plea, in this state or elsewhere, reasonably related to the practice
127.32 of the profession. Conviction, as used in this clause, includes a conviction of an offense

128.1 which, if committed in this state, would be deemed a felony, gross misdemeanor, or
128.2 misdemeanor, without regard to its designation elsewhere, or a criminal proceeding where
128.3 a finding or verdict of guilty is made or returned but the adjudication of guilt is either
128.4 withheld or not entered;
128.5 (4) making a misrepresentation in order to obtain or renew a license;
128.6 (5) displaying a pattern of practice or other behavior that demonstrates incapacity or
128.7 incompetence to practice;
128.8 (6) aiding or assisting another person in violating the provisions of this chapter;
128.9 (7) failing to provide information within 60 days in response to a written request from
128.10 the board, including documentation of completion of continuing education requirements;
128.11 (8) engaging in dishonorable, unethical, or unprofessional conduct;
128.12 (9) engaging in conduct of a character likely to deceive, defraud, or harm the public;
128.13 (10) inability to practice due to habitual intoxication, addiction to drugs, or mental
128.14 or physical illness;
128.15 (11) being disciplined by another state or territory of the United States, the federal
128.16 government, a national certification organization, or foreign nation, if at least one of the
128.17 grounds for the discipline is the same or substantially equivalent to one of the grounds
128.18 in this section;
128.19 (12) directly or indirectly giving to or receiving from a person, firm, corporation,
128.20 partnership, or association a fee, commission, rebate, or other form of compensation for
128.21 professional services not actually or personally rendered;
128.22 (13) incurring a finding by the board that the licensee, after the licensee has been
128.23 placed on probationary status, has violated the conditions of the probation;
128.24 (14) abandoning a patient or client;
128.25 (15) willfully making or filing false records or reports in the course of the licensee's
128.26 practice including, but not limited to, false records or reports filed with state or federal
128.27 agencies;
128.28 (16) willfully failing to report child maltreatment as required under the Maltreatment
128.29 of Minors Act, section 626.556; or
128.30 (17) soliciting professional services using false or misleading advertising.
128.31 (b) A license to practice is automatically suspended if (1) a guardian of a licensee is
128.32 appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons
128.33 other than the minority of the licensee, or (2) the licensee is committed by order of a court
128.34 pursuant to chapter 253B. The license remains suspended until the licensee is restored to
128.35 capacity by a court and, upon petition by the licensee, the suspension is terminated by the
128.36 board after a hearing. The licensee may be reinstated to practice, either with or without

129.1 restrictions, by demonstrating clear and convincing evidence of rehabilitation. The
129.2 regulated person is not required to prove rehabilitation if the subsequent court decision
129.3 overturns previous court findings of public risk.

129.4 (c) If the board has probable cause to believe that a licensee or applicant has violated
129.5 paragraph (a), clause (10), it may direct the person to submit to a mental or physical
129.6 examination. For the purpose of this section, every person is deemed to have consented to
129.7 submit to a mental or physical examination when directed in writing by the board and to
129.8 have waived all objections to the admissibility of the examining physician's testimony or
129.9 examination report on the grounds that the testimony or report constitutes a privileged
129.10 communication. Failure of a regulated person to submit to an examination when directed
129.11 constitutes an admission of the allegations against the person, unless the failure was due to
129.12 circumstances beyond the person's control, in which case a default and final order may be
129.13 entered without the taking of testimony or presentation of evidence. A regulated person
129.14 affected under this paragraph shall at reasonable intervals be given an opportunity to
129.15 demonstrate that the person can resume the competent practice of the regulated profession
129.16 with reasonable skill and safety to the public. In any proceeding under this paragraph,
129.17 neither the record of proceedings nor the orders entered by the board shall be used against
129.18 a regulated person in any other proceeding.

129.19 (d) In addition to ordering a physical or mental examination, the board may,
129.20 notwithstanding section 13.384 or 144.293, or any other law limiting access to medical or
129.21 other health data, obtain medical data and health records relating to a licensee or applicant
129.22 without the person's or applicant's consent if the board has probable cause to believe that a
129.23 licensee is subject to paragraph (a), clause (10). The medical data may be requested
129.24 from a provider as defined in section 144.291, subdivision 2, paragraph (i), an insurance
129.25 company, or a government agency, including the Department of Human Services. A
129.26 provider, insurance company, or government agency shall comply with any written request
129.27 of the board under this subdivision and is not liable in any action for damages for releasing
129.28 the data requested by the board if the data are released pursuant to a written request under
129.29 this subdivision, unless the information is false and the provider giving the information
129.30 knew, or had reason to know, the information was false. Information obtained under this
129.31 subdivision is private data on individuals as defined in section 13.02.

129.32 (e) If the board issues an order of immediate suspension of a license, a hearing must
129.33 be held within 30 days of the suspension and completed without delay.

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

129.35 **Sec. 51. [153B.75] INVESTIGATION; NOTICE AND HEARINGS.**

130.1 The board has the authority to investigate alleged violations of this chapter, conduct
130.2 hearings, and impose corrective or disciplinary action as provided in section 214.103.

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

130.4 Sec. 52. **[153B.80] UNLICENSED PRACTICE.**

130.5 Subdivision 1. **License required.** Effective January 1, 2018, no individual shall
130.6 practice as an orthotist, prosthetist, prosthetist orthotist, pedorthist, orthotic or prosthetic
130.7 assistant, or orthotic fitter, unless the individual holds a valid license issued by the board
130.8 under this chapter, except as permitted under section 153B.20 or 153B.35.

130.9 Subd. 2. **Designation.** No individual shall represent themselves to the public as
130.10 a licensed orthotist, prosthetist, prosthetist orthotist, pedorthist, orthotic or prosthetic
130.11 assistant, or an orthotic fitter, unless the individual is licensed under this chapter.

130.12 Subd. 3. **Penalties.** Any individual who violates this section is guilty of a
130.13 misdemeanor. The board shall have the authority to seek a cease and desist order against
130.14 any individual who is engaged in the unlicensed practice of a profession regulated by the
130.15 board under this chapter.

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

130.17 Sec. 53. **[153B.85] FEES.**

130.18 (a) The application fee for initial licensure shall not exceed \$600.

130.19 (b) The biennial renewal fee for a license to practice as an orthotist, prosthetist,
130.20 prosthetist orthotist, or pedorthist shall not exceed \$600.

130.21 (c) The biennial renewal fee for a license to practice as an assistant or a fitter shall
130.22 not exceed \$300.

130.23 (d) For the first renewal period following initial licensure, the renewal fee is the fee
130.24 specified in paragraph (b) or (c), prorated to the nearest dollar that is represented by the
130.25 ratio of the number of days the license is held in the initial licensure period to 730 days.

130.26 (e) The fee for license restoration shall not exceed \$600.

130.27 (f) The fee for late license renewal is the license renewal fee in effect at the time of
130.28 renewal plus \$100.

130.29 (g) The fee for license verification shall not exceed \$30.

130.30 (h) The fee to obtain a list of licensees shall not exceed \$25.

130.31 (i) No fee may be refunded for any reason.

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

131.1 Sec. 54. **FIRST APPOINTMENTS, FIRST MEETING, AND FIRST CHAIR OF**
131.2 **THE ORTHOTICS, PROSTHETICS, AND PEDORTHICS ADVISORY COUNCIL.**

131.3 The Board of Podiatric Medicine shall make its first appointments authorized
131.4 under Minnesota Statutes, section 153B.25, to the Orthotics, Prosthetics, and Pedorthics
131.5 Advisory Council, by September 1, 2016. The board shall designate four of its first
131.6 appointees to serve terms that are coterminous with the governor. The chair of the Board
131.7 of Podiatric Medicine or the chair's designee shall convene the first meeting of the council
131.8 by November 1, 2016. The council must elect a chair from among its members at the first
131.9 meeting of the council.

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

131.11 **ARTICLE 8**

131.12 **CONFORMING AMENDMENTS**

131.13 Section 1. Minnesota Statutes 2014, section 146A.06, subdivision 3, is amended to read:

131.14 Subd. 3. **Exchanging information.** (a) The office shall establish internal operating
131.15 procedures for:

131.16 (1) exchanging information with state boards; agencies, including the Office of
131.17 Ombudsman for Mental Health and Developmental Disabilities; health-related and law
131.18 enforcement facilities; departments responsible for licensing health-related occupations,
131.19 facilities, and programs; and law enforcement personnel in this and other states; and

131.20 (2) coordinating investigations involving matters within the jurisdiction of more
131.21 than one regulatory agency.

131.22 (b) The procedures for exchanging information must provide for the forwarding to
131.23 the entities described in paragraph (a), clause (1), of information and evidence, including
131.24 the results of investigations, that are relevant to matters within the regulatory jurisdiction
131.25 of the organizations in paragraph (a). The data have the same classification in the hands of
131.26 the agency receiving the data as they have in the hands of the agency providing the data.

131.27 (c) The office shall establish procedures for exchanging information with other
131.28 states regarding disciplinary action against unlicensed complementary and alternative
131.29 health care practitioners.

131.30 (d) The office shall forward to another governmental agency any complaints received
131.31 by the office that do not relate to the office's jurisdiction but that relate to matters within
131.32 the jurisdiction of the other governmental agency. The agency to which a complaint is
131.33 forwarded shall advise the office of the disposition of the complaint. A complaint or
131.34 other information received by another governmental agency relating to a statute or rule

132.1 that the office is empowered to enforce must be forwarded to the office to be processed
132.2 in accordance with this section.

132.3 (e) The office shall furnish to a person who made a complaint a description of the
132.4 actions of the office relating to the complaint.

132.5 (f) The office shall report to the Board of Nursing all final disciplinary actions
132.6 against individuals practicing massage and bodywork as unlicensed complementary and
132.7 alternative health practitioners. Upon request by the Board of Nursing, the office may
132.8 share all complaint, investigatory, and disciplinary data regarding a named individual who
132.9 has practiced or is practicing massage and bodywork as an unlicensed complementary and
132.10 complementary and alternative health practitioner.

132.11 Sec. 2. Minnesota Statutes 2014, section 146A.09, is amended by adding a subdivision
132.12 to read:

132.13 Subd. 8. **Registered massage and bodywork therapists.** No person whose
132.14 registration as a massage and bodywork therapist under sections 148.981 to 148.9886
132.15 has been suspended or revoked by the Board of Nursing may practice as an unlicensed
132.16 complementary and alternative health care practitioner under Minnesota Statutes, chapter
132.17 146A, during a period of suspension or revocation.

132.18 Sec. 3. **[325F.816] MUNICIPAL OR CITY BUSINESS LICENSE; MASSAGE.**

132.19 An individual who is issued a municipal or city business license to practice massage
132.20 is prohibited from advertising as a licensed massage and bodywork therapist unless the
132.21 individual has received a professional credential from another state, is current in licensure,
132.22 and remains in good standing under the credentialing state's requirements.

132.23 Sec. 4. **EFFECTIVE DATE.**

132.24 This article is effective August 1, 2016.

132.25 **ARTICLE 9**

132.26 **HUMAN SERVICES FORECAST ADJUSTMENTS**

132.27 Section 1. **HUMAN SERVICES APPROPRIATION.**

132.28 The sums shown in the columns marked "Appropriations" are added to or, if shown
132.29 in parentheses, subtracted from the appropriations in Laws 2015, chapter 71, article 13,
132.30 from the general fund or any fund named to the Department of Human Services for the
132.31 purposes specified in this article, to be available for the fiscal year indicated for each
132.32 purpose. The figures "2016" and "2017" used in this article mean that the appropriations

133.1 listed under them are available for the fiscal year ending June 30, 2016, or June 30, 2017,
 133.2 respectively. "The first year" is fiscal year 2016. "The second year" is fiscal year 2017.
 133.3 "The biennium" is fiscal years 2016 and 2017.

133.4 **APPROPRIATIONS**
 133.5 **Available for the Year**
 133.6 **Ending June 30**
 133.7 **2016 2017**

133.8 **Sec. 2. COMMISSIONER OF HUMAN**
 133.9 **SERVICES**

133.10 **Subdivision 1. Total Appropriation** **\$ (615,912,000) \$ (518,891,000)**

133.11 Appropriations by Fund

	<u>2016</u>	<u>2017</u>
133.12 <u>General Fund</u>	(307,806,000)	(246,029,000)
133.13 <u>Health Care Access</u>		
133.14 <u>Fund</u>	(289,770,000)	(277,101,000)
133.15 <u>Federal TANF</u>	(18,336,000)	4,239,000

133.17 **Subd. 2. Forecasted Programs**

133.18 **(a) MFIP/DWP**

	<u>Appropriations by Fund</u>	
	<u>2016</u>	<u>2017</u>
133.19 <u>General Fund</u>	9,833,000	(8,799,000)
133.20 <u>Federal TANF</u>	(20,225,000)	4,212,000
133.21 <u>(b) MFIP Child Care Assistance</u>	(23,094,000)	(7,760,000)
133.22 <u>(c) General Assistance</u>	(2,120,000)	(1,078,000)
133.23 <u>(d) Minnesota Supplemental Aid</u>	(1,613,000)	(1,650,000)
133.24 <u>(e) Group Residential Housing</u>	(8,101,000)	(7,954,000)
133.25 <u>(f) Northstar Care for Children</u>	2,231,000	4,496,000
133.26 <u>(g) MinnesotaCare</u>	(227,821,000)	(230,027,000)

133.28 These appropriations are from the health care
 133.29 access fund.

133.30 **(h) Medical Assistance**

	<u>Appropriations by Fund</u>	
	<u>2016</u>	<u>2017</u>
133.31 <u>General Fund</u>	(294,773,000)	(243,700,000)
133.32 <u>Health Care Access</u>		
133.33 <u>Fund</u>	(61,949,000)	(47,074,000)

134.1	<u>(i) Alternative Care Program</u>	<u>-0-</u>	<u>-0-</u>
134.2	<u>(j) CCDTF Entitlements</u>	<u>9,831,000</u>	<u>20,416,000</u>
134.3	<u>Subd. 3. Technical Activities</u>	<u>1,889,000</u>	<u>27,000</u>

134.4 These appropriations are from the federal
 134.5 TANF fund.

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

134.7 **ARTICLE 10**

134.8 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

134.9 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

134.10 The sums shown in the columns marked "Appropriations" are added to or, if shown
 134.11 in parentheses, subtracted from the appropriations in Laws 2015, chapter 71, article 14, to
 134.12 the agencies and for the purposes specified in this article. The appropriations are from the
 134.13 general fund or other named fund and are available for the fiscal years indicated for each
 134.14 purpose. The figures "2016" and "2017" used in this article mean that the addition to or
 134.15 subtraction from the appropriation listed under them is available for the fiscal year ending
 134.16 June 30, 2016, or June 30, 2017, respectively. Supplemental appropriations and reductions
 134.17 to appropriations for the fiscal year ending June 30, 2016, are effective the day following
 134.18 final enactment unless a different effective date is explicit.

134.19		<u>APPROPRIATIONS</u>	
134.20		<u>Available for the Year</u>	
134.21		<u>Ending June 30</u>	
134.22		<u>2016</u>	<u>2017</u>

134.23 **Sec. 2. COMMISSIONER OF HUMAN**
 134.24 **SERVICES**

134.25	<u>Subdivision 1. Total Appropriation</u>	<u>-0-</u>	<u>(3,032,000)</u>
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134.26	<u>Appropriations by Fund</u>		
134.27		<u>2016</u>	<u>2017</u>
134.28	<u>General</u>	<u>-0-</u>	<u>(2,147,000)</u>
134.29	<u>State Government</u>		
134.30	<u>Special Revenue</u>	<u>-0-</u>	<u>-0-</u>
134.31	<u>Health Care Access</u>	<u>-0-</u>	<u>(885,000)</u>
134.32	<u>Federal TANF</u>	<u>-0-</u>	<u>-0-</u>

134.33 **Subd. 2. Central Office Operations**

135.1 **(a) Operations**

135.2	<u>Appropriations by Fund</u>		
135.3	<u>General</u>	<u>-0-</u>	<u>(10,971,000)</u>
135.4	<u>State Government</u>		
135.5	<u>Special Revenue</u>	<u>-0-</u>	<u>-0-</u>
135.6	<u>Health Care Access</u>	<u>-0-</u>	<u>-0-</u>

135.7 **Base Adjustment.** The general fund base is
 135.8 reduced by \$11,853,000 in fiscal year 2018
 135.9 and \$11,650,000 in fiscal year 2019.

135.10 **(b) Children and Families** -0- -0-

135.11 **(c) Health Care**

135.12	<u>Appropriations by Fund</u>		
135.13	<u>General</u>	<u>-0-</u>	<u>162,000</u>
135.14	<u>Health Care Access</u>	<u>-0-</u>	<u>(943,000)</u>

135.15 **Waiver to Allow MinnesotaCare-Eligible**
 135.16 **Persons to Purchase Coverage Through**
 135.17 **Qualified Health Plans.** \$213,000 in fiscal
 135.18 year 2017 from the health care access fund is
 135.19 for the commissioner to request a waiver to
 135.20 allow persons eligible for MinnesotaCare to
 135.21 instead purchase coverage from a qualified
 135.22 health plan and access advanced premium
 135.23 tax credits and cost-sharing reductions. This
 135.24 is a onetime appropriation.

135.25 **Base Adjustment.** The general fund base is
 135.26 increased by \$142,000 in fiscal years 2018
 135.27 and 2019. The health care access fund base
 135.28 is reduced by \$1,142,000 in fiscal year 2018
 135.29 and \$1,153,000 in fiscal year 2019.

135.30 **(d) Continuing Care** -0- 201,000

135.31 **Long-Term Care Simulation Model.**
 135.32 (a) \$200,000 in fiscal year 2017 is for
 135.33 the commissioner of human resources to
 135.34 develop a Minnesota-specific long-term care

136.1 financing microsimulation model. This is a
 136.2 onetime appropriation. The commissioner
 136.3 shall ensure that the model:

136.4 (1) predicts the needs and future utilization
 136.5 of long-term care services and supports for
 136.6 Minnesotans based on demographic and
 136.7 economic factors; and

136.8 (2) estimates the costs of care under various
 136.9 funding scenarios, including voluntary
 136.10 programs, to determine the impact of
 136.11 various financing options on state funds,
 136.12 out-of-pocket expenses, Medicare, and other
 136.13 insurance and financing products.

136.14 (b) The commissioner shall use the
 136.15 appropriation in paragraph (a) to create and
 136.16 implement the model to:

136.17 (1) predict the cost of long-term care under
 136.18 various public and private financing options,
 136.19 including voluntary programs; and

136.20 (2) determine the most appropriate options
 136.21 for the state.

136.22 (c) The commissioner shall report by January
 136.23 15, 2018, to the chairs and ranking minority
 136.24 members of the legislative committees and
 136.25 divisions with jurisdiction over health and
 136.26 human services policy and finance on the
 136.27 development of the long-term care simulation
 136.28 model.

136.29 (d) Notwithstanding any contrary provision
 136.30 in this article, paragraphs (a) to (c) expire
 136.31 January 15, 2018.

136.32 **(e) Community Supports**

-0-

74,000

137.1	<u>Base Adjustment.</u> The general fund base		
137.2	is increased by \$543,000 in fiscal year 2018		
137.3	and \$503,000 in fiscal year 2019.		
137.4	<u>Subd. 3. Forecasted Programs</u>		
137.5	<u>(a) MFIP/DWP</u>		
137.6	<u>Appropriations by Fund</u>		
137.7	<u>General</u>	-0-	
137.8	<u>Federal TANF</u>	-0-	
137.9	<u>(b) MFIP Child Care Assistance</u>	-0-	-0-
137.10	<u>(c) General Assistance</u>	-0-	-0-
137.11	<u>(d) MN Supplemental Assistance</u>	-0-	-0-
137.12	<u>(e) Group Residential Housing</u>	-0-	-0-
137.13	<u>(f) Northstar Care for Children</u>	-0-	-0-
137.14	<u>(g) MinnesotaCare</u>	-0-	<u>58,000</u>
137.15	<u>These appropriations are from the health care</u>		
137.16	<u>access fund.</u>		
137.17	<u>(h) Medical Assistance</u>		
137.18	<u>Appropriations by Fund</u>		
137.19	<u>General</u>	-0-	<u>252,000</u>
137.20	<u>Health Care Access</u>	-0-	-0-
137.21	<u>(i) Alternative Care</u>	-0-	-0-
137.22	<u>(j) CD Treatment Fund</u>	-0-	<u>3,792,000</u>
137.23	<u>Transfer.</u> Notwithstanding Minnesota		
137.24	<u>Statutes, section 254B.06, subdivision 1, the</u>		
137.25	<u>commissioner shall transfer up to \$2,000,000,</u>		
137.26	<u>if available, in fiscal year 2017 only, from the</u>		
137.27	<u>consolidated chemical dependency treatment</u>		
137.28	<u>fund administrative account in the special</u>		
137.29	<u>revenue fund to the general fund.</u>		
137.30	<u>Subd. 4. Grant Programs</u>		
137.31	<u>(a) Support Services Grants</u>	-0-	-0-

138.1	<u>(b) BSF Child Care Assistance Grants</u>	<u>-0-</u>	<u>-0-</u>
138.2	<u>Base Adjustment.</u> The general fund base		
138.3	is increased by \$174,000 in fiscal year 2018		
138.4	and \$232,000 in fiscal year 2019.		
138.5	<u>(c) Child Care Development Grants</u>	<u>-0-</u>	<u>-0-</u>
138.6	<u>(d) Child Support Enforcement Grants</u>	<u>-0-</u>	<u>-0-</u>
138.7	<u>(e) Children's Services Grants</u>	<u>-0-</u>	<u>-0-</u>
138.8	<u>(f) Children and Community Service Grants</u>	<u>-0-</u>	<u>1,400,000</u>
138.9	<u>White Earth Band of Ojibwe Human</u>		
138.10	<u>Services Initiative Project.</u> \$1,400,000		
138.11	in fiscal year 2017 is for a grant to the		
138.12	White Earth Band of Ojibwe for the direct		
138.13	implementation and administrative costs of		
138.14	the White Earth Human Services Initiative		
138.15	Project authorized under Laws 2011, First		
138.16	Special Session chapter 9, article 9, section		
138.17	18. This is a onetime appropriation.		
138.18	<u>(g) Children and Economic Support Grants</u>	<u>-0-</u>	<u>934,000</u>
138.19	<u>Safe Harbor.</u> \$934,000 in fiscal year 2017		
138.20	from the general fund is for emergency shelter		
138.21	and transitional and long-term housing beds		
138.22	for sexually exploited youth and youth at		
138.23	risk of sexual exploitation, and for statewide		
138.24	youth outreach workers to connect sexually		
138.25	exploited youth with shelter and services.		
138.26	<u>(h) Health Care Grants</u>	<u>-0-</u>	<u>-0-</u>
138.27	<u>(i) Other Long-Term Care Grants</u>	<u>-0-</u>	<u>-0-</u>
138.28	<u>(j) Aging and Adult Services Grants</u>	<u>-0-</u>	<u>40,000</u>
138.29	<u>Advanced In-Home Activity Monitoring</u>		
138.30	<u>Systems.</u> \$40,000 in fiscal year 2017 from the		
138.31	general fund is for a grant to a local research		
138.32	organization with expertise in identifying		

139.1 current and potential support systems and
 139.2 examining the capacity of those systems to
 139.3 meet the needs of the growing population of
 139.4 elderly persons, to conduct a comprehensive
 139.5 assessment of current literature, past
 139.6 research, and an environmental scan of the
 139.7 field related to advanced in-home activity
 139.8 monitoring systems for elderly persons.
 139.9 The commissioner must report the results
 139.10 of the assessment by January 15, 2017, to
 139.11 the legislative committees and divisions with
 139.12 jurisdiction over health and human services
 139.13 policy and finance.

139.14 **Base Adjustment.** The general fund base
 139.15 is increased by \$40,000 in fiscal years 2018
 139.16 and 2019.

139.17	<u>(k) Deaf and Hard-of-Hearing Grants</u>	<u>-0-</u>	<u>-0-</u>
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139.18	<u>(l) Disabilities Grants</u>	<u>-0-</u>	<u>-0-</u>
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139.19	<u>(m) Adult Mental Health Grants</u>	<u>-0-</u>	<u>394,000</u>
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139.20 **Mental Health Pilot Project.** \$394,000
 139.21 in fiscal year 2017 from the general fund
 139.22 is for a grant to the Zumbro Valley Health
 139.23 Center. The grant shall be used to continue a
 139.24 pilot project to test an integrated behavioral
 139.25 health care coordination model. The grant
 139.26 recipient must report measurable outcomes
 139.27 to the commissioner of human services by
 139.28 December 1, 2018. This appropriation does
 139.29 not expire and is available through June 30,
 139.30 2018.

139.31	<u>(n) Child Mental Health Grants</u>	<u>-0-</u>	<u>600,000</u>
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139.32 **Children's Mental Health Collaboratives.**
 139.33 \$600,000 in fiscal year 2017 from the general
 139.34 fund is for a children's mental health grant

140.1 under Minnesota Statutes, section 245.4889,
 140.2 for a rural demonstration project to assist
 140.3 transition-aged youth and young adults
 140.4 with emotional behavioral disturbance or
 140.5 mental illnesses in making a successful
 140.6 transition into adulthood. This is a onetime
 140.7 appropriation.

140.8 **(o) Chemical Dependency Treatment Support**
 140.9 **Grants**

-0-

975,000

140.10 **Peer Specialists.** \$800,000 in fiscal year
 140.11 2017 from the general fund is for grants
 140.12 to recovery community organizations to
 140.13 train, hire, and supervise peer specialists
 140.14 to work with underserved populations as
 140.15 part of the continuum of care for substance
 140.16 use disorders. Recovery community
 140.17 organizations located in Rochester,
 140.18 Moorhead, and the Twin Cities metropolitan
 140.19 area are eligible to receive grant funds.

140.20 **Recovery Community Organizations.**
 140.21 \$175,000 in fiscal year 2017 from the
 140.22 general fund is for a grant to recovery
 140.23 community organizations to create and
 140.24 implement a public relations campaign
 140.25 specific to reducing the stigma associated
 140.26 with substance use disorders. Recovery
 140.27 community organizations located in
 140.28 Rochester, Moorhead, and the Twin Cities
 140.29 metropolitan area are eligible to receive grant
 140.30 funds.

140.31 **Base Adjustment.** The general fund base is
 140.32 increased by \$800,000 in fiscal years 2018
 140.33 and 2019.

140.34 **Subd. 5. DCT State-Operated Services**

141.1	<u>(a) DCT State-Operated Services Mental</u>			
141.2	<u>Health</u>		<u>-0-</u>	<u>-0-</u>
141.3	<u>(b) DCT State-Operated Services Enterprise</u>			
141.4	<u>Services</u>		<u>-0-</u>	<u>-0-</u>
141.5	<u>(c) DCT State-Operated Services Minnesota</u>			
141.6	<u>Security Hospital</u>		<u>-0-</u>	<u>-0-</u>
141.7	<u>Subd. 6. DCT Minnesota Sex Offender</u>			
141.8	<u>Program</u>		<u>-0-</u>	<u>-0-</u>
141.9	<u>Subd. 7. Technical Activities</u>		<u>-0-</u>	<u>-0-</u>
141.10	<u>Sec. 3. COMMISSIONER OF HEALTH</u>			
141.11	<u>Subdivision 1. Total Appropriation</u>	\$	<u>-0-</u>	<u>\$ 1,813,000</u>
141.12	<u>Appropriations by Fund</u>			
141.13		<u>2016</u>	<u>2017</u>	
141.14	<u>General</u>	<u>-0-</u>	<u>315,000</u>	
141.15	<u>Health Care Access</u>	<u>-0-</u>	<u>1,000,000</u>	
141.16	<u>State Government</u>			
141.17	<u>Special Revenue</u>	<u>-0-</u>	<u>498,000</u>	
141.18	<u>The appropriation modifications for each</u>			
141.19	<u>purpose are shown in subdivisions 2 and 3.</u>			
141.20	<u>Subd. 2. Health Improvement</u>			
141.21	<u>Appropriations by Fund</u>			
141.22	<u>General</u>	<u>-0-</u>	<u>315,000</u>	
141.23	<u>Health Care Access</u>	<u>-0-</u>	<u>1,000,000</u>	
141.24	<u>State Government</u>			
141.25	<u>Special Revenue</u>	<u>-0-</u>	<u>498,000</u>	
141.26	<u>Greater Minnesota Family Residency</u>			
141.27	<u>Program.</u> \$1,000,000 in fiscal year 2017			
141.28	<u>from the health care access fund is for the</u>			
141.29	<u>commissioner of health to award grants</u>			
141.30	<u>for the greater Minnesota family residency</u>			
141.31	<u>program.</u>			
141.32	<u>Reporting on Health Care Costs and</u>			
141.33	<u>Volume.</u> \$250,000 in fiscal year 2017 from			
141.34	<u>the general fund is for the commissioner of</u>			
141.35	<u>health to expand public reporting on average</u>			

142.1 cost and volume information for procedures,
 142.2 tests, and services from clinics, medical
 142.3 groups, and hospitals for those procedures,
 142.4 tests, and services that the commissioner
 142.5 determines most impact the quality of care
 142.6 and patient outcomes under Minnesota
 142.7 Statutes, section 62U.02. The commissioner
 142.8 may contract with an external vendor in
 142.9 conducting the work.

142.10 **Base Adjustments.** The general fund base is
 142.11 increased by \$2,094,000 in fiscal years 2018
 142.12 and 2019. The health care access fund base
 142.13 is increased by \$1,000,000 in fiscal years
 142.14 2018 and 2019.

142.15 **Subd. 3. Health Protection** -0- -0-

142.16 **Sec. 4. HEALTH-RELATED BOARDS**

142.17 **Subdivision 1. Total Appropriation** \$ -0- \$ **354,000**

142.18 This appropriation is from the state
 142.19 government special revenue fund.

142.20 **Subd. 2. Genetic Counselors** -0- 22,000

142.21 **Subd. 3. Board of Nursing** -0- 257,000

142.22 **Subd. 4. Board of Podiatric Medicine** -0- 75,000

142.23 **Sec. 5. EMS REGULATORY BOARD** \$ **70,000** \$ **55,000**

142.24 **EMS Technology.** Of these appropriations:

142.25 (1) \$34,000 in fiscal year 2016 and
 142.26 \$34,000 in fiscal year 2017 are for annual
 142.27 support, maintenance, and hosting of the
 142.28 comprehensive electronic licensing and
 142.29 agency operations software solution;

142.30 (2) \$21,000 in fiscal year 2016 and \$21,000
 142.31 in fiscal year 2017 are for annual support,

143.1 maintenance, and housing of the MNSTAR
 143.2 prehospital patient care report database; and
 143.3 (3) \$15,000 in fiscal year 2016 is for the
 143.4 board to purchase four 800-megahertz
 143.5 handheld radios to be used by field staff to
 143.6 meet board responsibilities for emergency
 143.7 communications during a regional or
 143.8 statewide emergency.

143.9 This provision is effective the day following
 143.10 final enactment.

143.11 **Sec. 6. OMBUDSMAN FOR MENTAL**
 143.12 **HEALTH AND DEVELOPMENTAL**
 143.13 **DISABILITIES**

\$ -0- \$ 250,000

143.14 These funds are for two positions for the
 143.15 Jensen Settlement and Minnesota's Olmstead
 143.16 Plan System Division, for oversight and
 143.17 systematic monitoring for the Jensen and
 143.18 Olmstead implementation plans and to fulfill
 143.19 the duties as a consultant to the court and all
 143.20 parties, as appointed by the federal court.

143.21 Sec. 7. Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended by
 143.22 Laws 2015, First Special Session chapter 6, section 1, is amended to read:

143.23 **Subd. 5. Grant Programs**

143.24 The amounts that may be spent from this
 143.25 appropriation for each purpose are as follows:

143.26 **(a) Support Services Grants**

143.27	Appropriations by Fund		
143.28	General	13,133,000	8,715,000
143.29	Federal TANF	96,311,000	96,311,000

143.30	(b) Basic Sliding Fee Child Care Assistance		
143.31	Grants	48,439,000	51,559,000

143.32 **Basic Sliding Fee Waiting List Allocation.**
 143.33 Notwithstanding Minnesota Statutes, section

144.1 119B.03, \$5,413,000 in fiscal year 2016 is to
 144.2 reduce the basic sliding fee program waiting
 144.3 list as follows:

144.4 (1) The calendar year 2016 allocation shall
 144.5 be increased to serve families on the waiting
 144.6 list. To receive funds appropriated for this
 144.7 purpose, a county must have:

144.8 (i) a waiting list in the most recent published
 144.9 waiting list month;

144.10 (ii) an average of at least ten families on the
 144.11 most recent six months of published waiting
 144.12 list; and

144.13 (iii) total expenditures in calendar year
 144.14 2014 that met or exceeded 80 percent of the
 144.15 county's available final allocation.

144.16 (2) Funds shall be distributed proportionately
 144.17 based on the average of the most recent six
 144.18 months of published waiting lists to counties
 144.19 that meet the criteria in clause (1).

144.20 (3) Allocations in calendar years 2017
 144.21 and beyond shall be calculated using the
 144.22 allocation formula in Minnesota Statutes,
 144.23 section 119B.03.

144.24 (4) The guaranteed floor for calendar year
 144.25 2017 shall be based on the revised calendar
 144.26 year 2016 allocation.

144.27 **Base Level Adjustment.** The general fund
 144.28 base is increased by \$810,000 in fiscal year
 144.29 2018 and increased by \$821,000 in fiscal
 144.30 year 2019.

144.31	(c) Child Care Development Grants	1,737,000	1,737,000
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144.32	(d) Child Support Enforcement Grants	50,000	50,000
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144.33 (e) **Children's Services Grants**

145.1	Appropriations by Fund		
145.2	General	39,015,000	38,665,000
145.3	Federal TANF	140,000	140,000

145.4 **Safe Place for Newborns.** \$350,000 from
 145.5 the general fund in fiscal year 2016 is to
 145.6 distribute information on the Safe Place
 145.7 for Newborns law in Minnesota to increase
 145.8 public awareness of the law. This is a
 145.9 onetime appropriation.

145.10 **Child Protection.** \$23,350,000 in fiscal
 145.11 year 2016 and \$23,350,000 in fiscal year
 145.12 2017 are to address child protection staffing
 145.13 and services under Minnesota Statutes,
 145.14 section 256M.41. \$1,650,000 in fiscal year
 145.15 2016 and \$1,650,000 in fiscal year 2017
 145.16 are for child protection grants to address
 145.17 child welfare disparities under Minnesota
 145.18 Statutes, section 256E.28. Of the fiscal
 145.19 year 2017 appropriation to address child
 145.20 protection staffing and services in 2017 only,
 145.21 \$1,600,000 is for a grant to the White Earth
 145.22 Band of Ojibwe for purposes of delivering
 145.23 child welfare services.

145.24 **Title IV-E Adoption Assistance.** Additional
 145.25 federal reimbursement to the state as a result
 145.26 of the Fostering Connections to Success
 145.27 and Increasing Adoptions Act's expanded
 145.28 eligibility for title IV-E adoption assistance
 145.29 is appropriated to the commissioner
 145.30 for postadoption services, including a
 145.31 parent-to-parent support network.

145.32 **Adoption Assistance Incentive Grants.**
 145.33 Federal funds available during fiscal years
 145.34 2016 and 2017 for adoption incentive
 145.35 grants are appropriated to the commissioner

146.1 for postadoption services, including a
 146.2 parent-to-parent support network.

146.3 **(f) Children and Community Service Grants** 56,301,000 56,301,000

146.4 **(g) Children and Economic Support Grants** 26,778,000 26,966,000

146.5 **Mobile Food Shelf Grants.** (a) \$1,000,000
 146.6 in fiscal year 2016 and \$1,000,000 in
 146.7 fiscal year 2017 are for a grant to Hunger
 146.8 Solutions. This is a onetime appropriation
 146.9 and is available until June 30, 2017.

146.10 (b) Hunger Solutions shall award grants of
 146.11 up to \$75,000 on a competitive basis. Grant
 146.12 applications must include:

146.13 (1) the location of the project;

146.14 (2) a description of the mobile program,
 146.15 including size and scope;

146.16 (3) evidence regarding the unserved or
 146.17 underserved nature of the community in
 146.18 which the project is to be located;

146.19 (4) evidence of community support for the
 146.20 project;

146.21 (5) the total cost of the project;

146.22 (6) the amount of the grant request and how
 146.23 funds will be used;

146.24 (7) sources of funding or in-kind
 146.25 contributions for the project that will
 146.26 supplement any grant award;

146.27 (8) a commitment to mobile programs by the
 146.28 applicant and an ongoing commitment to
 146.29 maintain the mobile program; and

146.30 (9) any additional information requested by
 146.31 Hunger Solutions.

146.32 (c) Priority may be given to applicants who:

- 147.1 (1) serve underserved areas;
- 147.2 (2) create a new or expand an existing mobile
147.3 program;
- 147.4 (3) serve areas where a high amount of need
147.5 is identified;
- 147.6 (4) provide evidence of strong support for the
147.7 project from citizens and other institutions in
147.8 the community;
- 147.9 (5) leverage funding for the project from
147.10 other private and public sources; and
- 147.11 (6) commit to maintaining the program on a
147.12 multilayer basis.
- 147.13 **Homeless Youth Act.** At least \$500,000 of
147.14 the appropriation for the Homeless Youth
147.15 Act must be awarded to providers in greater
147.16 Minnesota, with at least 25 percent of this
147.17 amount for new applicant providers. The
147.18 commissioner shall provide outreach and
147.19 technical assistance to greater Minnesota
147.20 providers and new providers to encourage
147.21 responding to the request for proposals.
- 147.22 **Stearns County Veterans Housing.**
147.23 \$85,000 in fiscal year 2016 and \$85,000
147.24 in fiscal year 2017 are for a grant to
147.25 Stearns County to provide administrative
147.26 funding in support of a service provider
147.27 serving veterans in Stearns County. The
147.28 administrative funding grant may be used to
147.29 support group residential housing services,
147.30 corrections-related services, veteran services,
147.31 and other social services related to the service
147.32 provider serving veterans in Stearns County.
- 147.33 **Safe Harbor.** \$800,000 in fiscal year 2016
147.34 and \$800,000 in fiscal year 2017 are from

148.1 the general fund for emergency shelter and
 148.2 transitional and long-term housing beds for
 148.3 sexually exploited youth and youth at risk of
 148.4 sexual exploitation. Of this appropriation,
 148.5 \$150,000 in fiscal year 2016 and \$150,000 in
 148.6 fiscal year 2017 are from the general fund for
 148.7 statewide youth outreach workers connecting
 148.8 sexually exploited youth and youth at risk of
 148.9 sexual exploitation with shelter and services.

148.10 **Minnesota Food Assistance Program.**

148.11 Unexpended funds for the Minnesota food
 148.12 assistance program for fiscal year 2016 do
 148.13 not cancel but are available for this purpose
 148.14 in fiscal year 2017.

148.15 **Base Level Adjustment.** The general fund
 148.16 base is decreased by \$816,000 in fiscal year
 148.17 2018 and is decreased by \$606,000 in fiscal
 148.18 year 2019.

148.19 **(h) Health Care Grants**

148.20	Appropriations by Fund		
148.21	General	536,000	2,482,000
148.22	Health Care Access	3,341,000	3,465,000

148.23 **Grants for Periodic Data Matching for**
 148.24 **Medical Assistance and MinnesotaCare.**

148.25 Of the general fund appropriation, \$26,000
 148.26 in fiscal year 2016 and \$1,276,000 in fiscal
 148.27 year 2017 are for grants to counties for
 148.28 costs related to periodic data matching
 148.29 for medical assistance and MinnesotaCare
 148.30 recipients under Minnesota Statutes,
 148.31 section 256B.0561. The commissioner
 148.32 must distribute these grants to counties in
 148.33 proportion to each county's number of cases
 148.34 in the prior year in the affected programs.

149.1 **Base Level Adjustment.** The general fund
 149.2 base is increased by \$1,637,000 in fiscal year
 149.3 2018 and increased by \$1,229,000 in fiscal
 149.4 year 2019.

149.5 **(i) Other Long-Term Care Grants** 1,551,000 3,069,000

149.6 **Transition Populations.** \$1,551,000 in fiscal
 149.7 year 2016 and \$1,725,000 in fiscal year 2017
 149.8 are for home and community-based services
 149.9 transition grants to assist in providing home
 149.10 and community-based services and treatment
 149.11 for transition populations under Minnesota
 149.12 Statutes, section 256.478.

149.13 **Base Level Adjustment.** The general fund
 149.14 base is increased by \$156,000 in fiscal year
 149.15 2018 and by \$581,000 in fiscal year 2019.

149.16 **(j) Aging and Adult Services Grants** 28,463,000 28,162,000

149.17 **Dementia Grants.** \$750,000 in fiscal year
 149.18 2016 and \$750,000 in fiscal year 2017
 149.19 are for the Minnesota Board on Aging for
 149.20 regional and local dementia grants authorized
 149.21 in Minnesota Statutes, section 256.975,
 149.22 subdivision 11.

149.23 **(k) Deaf and Hard-of-Hearing Grants** 2,225,000 2,375,000

149.24 **Deaf, Deafblind, and Hard-of-Hearing**
 149.25 **Grants.** \$350,000 in fiscal year 2016 and
 149.26 \$500,000 in fiscal year 2017 are for deaf
 149.27 and hard-of-hearing grants. The funds
 149.28 must be used to increase the number of
 149.29 deafblind Minnesotans receiving services
 149.30 under Minnesota Statutes, section 256C.261,
 149.31 and to provide linguistically and culturally
 149.32 appropriate mental health services to children
 149.33 who are deaf, deafblind, and hard-of-hearing.
 149.34 This is a onetime appropriation.

150.1 **Base Level Adjustment.** The general fund
 150.2 base is decreased by \$500,000 in fiscal year
 150.3 2018 and by \$500,000 in fiscal year 2019.

150.4 **(l) Disabilities Grants** 20,820,000 20,858,000

150.5 **State Quality Council.** \$573,000 in fiscal
 150.6 year 2016 and \$600,000 in fiscal year
 150.7 2017 are for the State Quality Council to
 150.8 provide technical assistance and monitoring
 150.9 of person-centered outcomes related to
 150.10 inclusive community living and employment.
 150.11 The funding must be used by the State
 150.12 Quality Council to assure a statewide plan
 150.13 for systems change in person-centered
 150.14 planning that will achieve desired outcomes
 150.15 including increased integrated employment
 150.16 and community living.

150.17 **(m) Adult Mental Health Grants**

150.18	Appropriations by Fund		
150.19	General	69,992,000	71,244,000
150.20	Health Care Access	1,575,000	2,473,000
150.21	Lottery Prize	1,733,000	1,733,000

150.22 **Funding Usage.** Up to 75 percent of a fiscal
 150.23 year's appropriation for adult mental health
 150.24 grants may be used to fund allocations in that
 150.25 portion of the fiscal year ending December
 150.26 31.

150.27 **Culturally Specific Mental Health**
 150.28 **Services.** \$100,000 in fiscal year 2016 is for
 150.29 grants to nonprofit organizations to provide
 150.30 resources and referrals for culturally specific
 150.31 mental health services to Southeast Asian
 150.32 veterans born before 1965 who do not qualify
 150.33 for services available to veterans formally
 150.34 discharged from the United States armed
 150.35 forces.

151.1 **Problem Gambling.** \$225,000 in fiscal year
 151.2 2016 and \$225,000 in fiscal year 2017 are
 151.3 from the lottery prize fund for a grant to the
 151.4 state affiliate recognized by the National
 151.5 Council on Problem Gambling. The affiliate
 151.6 must provide services to increase public
 151.7 awareness of problem gambling, education,
 151.8 and training for individuals and organizations
 151.9 providing effective treatment services to
 151.10 problem gamblers and their families, and
 151.11 research related to problem gambling.

151.12 **Sustainability Grants.** \$2,125,000 in fiscal
 151.13 year 2016 and \$2,125,000 in fiscal year 2017
 151.14 are for sustainability grants under Minnesota
 151.15 Statutes, section 256B.0622, subdivision 11.

151.16 **Beltrami County Mental Health Services**
 151.17 **Grant.** \$1,000,000 in fiscal year 2016 and
 151.18 \$1,000,000 in fiscal year 2017 are from the
 151.19 general fund for a grant to Beltrami County
 151.20 to fund the planning and development of
 151.21 a comprehensive mental health services
 151.22 program under article 2, section 41,
 151.23 Comprehensive Mental Health Program
 151.24 in Beltrami County. This is a onetime
 151.25 appropriation.

151.26 **Base Level Adjustment.** The general fund
 151.27 base is increased by \$723,000 in fiscal year
 151.28 2018 and by \$723,000 in fiscal year 2019.
 151.29 The health care access fund base is decreased
 151.30 by \$1,723,000 in fiscal year 2018 and by
 151.31 \$1,723,000 in fiscal year 2019.

151.32 (n) Child Mental Health Grants	23,386,000	24,313,000
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151.33 **Services and Supports for First Episode**
 151.34 **Psychosis.** \$177,000 in fiscal year 2017 is
 151.35 for grants under Minnesota Statutes, section

152.1 245.4889, to mental health providers to pilot
 152.2 evidence-based interventions for youth at risk
 152.3 of developing or experiencing a first episode
 152.4 of psychosis and for a public awareness
 152.5 campaign on the signs and symptoms of
 152.6 psychosis. The base for these grants is
 152.7 \$236,000 in fiscal year 2018 and \$301,000 in
 152.8 fiscal year 2019.

152.9 **Adverse Childhood Experiences.** The base
 152.10 for grants under Minnesota Statutes, section
 152.11 245.4889, to children's mental health and
 152.12 family services collaboratives for adverse
 152.13 childhood experiences (ACEs) training
 152.14 grants and for an interactive Web site
 152.15 connection to support ACEs in Minnesota is
 152.16 \$363,000 in fiscal year 2018 and \$363,000 in
 152.17 fiscal year 2019.

152.18 **Funding Usage.** Up to 75 percent of a fiscal
 152.19 year's appropriation for child mental health
 152.20 grants may be used to fund allocations in that
 152.21 portion of the fiscal year ending December
 152.22 31.

152.23 **Base Level Adjustment.** The general fund
 152.24 base is increased by \$422,000 in fiscal year
 152.25 2018 and is increased by \$487,000 in fiscal
 152.26 year 2019.

152.27 (o) **Chemical Dependency Treatment Support**
 152.28 **Grants**

1,561,000

1,561,000

152.29 **Chemical Dependency Prevention.**
 152.30 \$150,000 in fiscal year 2016 and \$150,000
 152.31 in fiscal year 2017 are for grants to
 152.32 nonprofit organizations to provide chemical
 152.33 dependency prevention programs in
 152.34 secondary schools. When making grants, the
 152.35 commissioner must consider the expertise,

153.1 prior experience, and outcomes achieved
 153.2 by applicants that have provided prevention
 153.3 programming in secondary education
 153.4 environments. An applicant for the grant
 153.5 funds must provide verification to the
 153.6 commissioner that the applicant has available
 153.7 and will contribute sufficient funds to match
 153.8 the grant given by the commissioner. This is
 153.9 a onetime appropriation.

153.10 **Fetal Alcohol Syndrome Grants.** \$250,000
 153.11 in fiscal year 2016 and \$250,000 in fiscal year
 153.12 2017 are for grants to be administered by the
 153.13 Minnesota Organization on Fetal Alcohol
 153.14 Syndrome to provide comprehensive,
 153.15 gender-specific services to pregnant and
 153.16 parenting women suspected of or known
 153.17 to use or abuse alcohol or other drugs.
 153.18 This appropriation is for grants to no fewer
 153.19 than three eligible recipients. Minnesota
 153.20 Organization on Fetal Alcohol Syndrome
 153.21 must report to the commissioner of human
 153.22 services annually by January 15 on the
 153.23 grants funded by this appropriation. The
 153.24 report must include measurable outcomes for
 153.25 the previous year, including the number of
 153.26 pregnant women served and the number of
 153.27 toxic-free babies born.

153.28 **Base Level Adjustment.** The general fund
 153.29 base is decreased by \$150,000 in fiscal year
 153.30 2018 and by \$150,000 in fiscal year 2019.

153.31 Sec. 8. Laws 2015, chapter 71, article 14, section 4, subdivision 1, is amended to read:

153.32			19,707,000		19,597,000
153.33	Subdivision 1. Total Appropriation	\$	<u>19,902,000</u>	\$	<u>19,852,000</u>

153.34 This appropriation is from the state
 153.35 government special revenue fund. The

154.1 amounts that may be spent for each purpose
 154.2 are specified in the following subdivisions.

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

154.4 Sec. 9. Laws 2015, chapter 71, article 14, section 4, subdivision 3, is amended to read:

154.5		2,192,000	2,206,000
154.6	Subd. 3. Board of Dentistry	<u>1,342,000</u>	<u>1,342,000</u>

154.7 ~~This appropriation includes \$864,000 in fiscal~~
 154.8 ~~year 2016 and \$878,000 in fiscal year 2017~~
 154.9 ~~for the health professional services program.~~

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

154.11 Sec. 10. Laws 2015, chapter 71, article 14, section 4, subdivision 5, is amended to read:

154.12	Subd. 5. Board of Marriage and Family	234,000	237,000
154.13	Therapy	<u>274,000</u>	<u>287,000</u>

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

154.15 Sec. 11. Laws 2015, chapter 71, article 14, section 4, subdivision 10, is amended to read:

154.16		2,847,000	2,888,000
154.17	Subd. 10. Board of Pharmacy	<u>2,962,000</u>	<u>3,033,000</u>

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

154.19 Sec. 12. Laws 2015, chapter 71, article 14, section 4, subdivision 11, is amended to read:

154.20		354,000	359,000
154.21	Subd. 11. Board of Physical Therapy	<u>1,244,000</u>	<u>1,283,000</u>

154.22 **Health Professional Services Program. Of**
 154.23 this appropriation, \$850,000 in fiscal year
 154.24 2016 and \$864,000 in fiscal year 2017 from
 154.25 the state government special revenue fund are
 154.26 for the health professional services program.

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

154.28 Sec. 13. Laws 2015, chapter 71, article 14, section 9, is amended to read:

155.1			210,000	213,000
155.2	Sec. 9. COMMISSIONER OF COMMERCE	\$	<u>-0-</u> \$	<u>-0-</u>

155.3 The commissioner of commerce shall
 155.4 develop a proposal to allow individuals
 155.5 to purchase qualified health plans outside
 155.6 of MNsure directly from health plan
 155.7 companies and to allow eligible individuals
 155.8 to receive advanced premium tax credits and
 155.9 cost-sharing reductions when purchasing
 155.10 qualified health plans outside of MNsure.

155.11 Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

155.12 All uncodified language contained in this article expires on June 30, 2017, unless a
 155.13 different expiration date is explicit.

155.14 Sec. 15. **EFFECTIVE DATE.**

155.15 This article is effective the day following final enactment.

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Article locations in H3467-1

ARTICLE 1	CONTINUING CARE	Page.Ln 2.6
ARTICLE 2	HEALTH CARE	Page.Ln 19.1
ARTICLE 3	MNSURE	Page.Ln 28.8
ARTICLE 4	HEALTH DEPARTMENT	Page.Ln 38.18
ARTICLE 5	CHEMICAL AND MENTAL HEALTH	Page.Ln 56.26
ARTICLE 6	CHILDREN AND FAMILIES	Page.Ln 69.11
ARTICLE 7	HEALTH-RELATED LICENSING	Page.Ln 87.6
ARTICLE 8	CONFORMING AMENDMENTS	Page.Ln 131.11
ARTICLE 9	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 132.25
ARTICLE 10	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 134.7

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

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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.

(d) 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.

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

(f) 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.

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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.

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(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

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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

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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.

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(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.

(e) An appellant aggrieved by an order of MNsure issued in an eligibility appeal, as defined in Minnesota Rules, part 7700.0101, may appeal the order to the district court of the appellant's county of residence by serving a written copy of a notice of appeal upon MNsure and any other adverse party of record within 30 days after the date MNsure issued the order, the amended order, or order affirming the original order, and by filing the original notice and proof of service with the court administrator of the district court. Service may be made personally or by mail; service by mail is complete upon mailing; no filing fee shall be required by the court administrator in appeals taken pursuant to this subdivision. MNsure shall furnish all parties to the proceedings with a copy of the decision and a transcript of any testimony, evidence, or other supporting papers from the hearing held before the appeals examiner within 45 days after service of the notice of appeal.

(f) Any party aggrieved by the failure of an adverse party to obey an order issued by MNsure may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

(g) Any party may obtain a hearing at a special term of the district court by serving a written notice of the time and place of the hearing at least ten days prior to the date of the hearing. The court may consider the matter in or out of chambers, and shall take no new or additional evidence unless it determines that such evidence is necessary for a more equitable disposition of the appeal.

(h) Any party aggrieved by the order of the district court may appeal the order as in other civil cases. No costs or disbursements shall be taxed against any party nor shall any filing fee or bond be required of any party.

(i) If MNsure or district court orders eligibility for qualified health plan coverage through MNsure, or eligibility for federal advance payment of premium tax credits or cost-sharing reductions contingent upon full payment of respective premiums, the premiums must be paid or provided pending appeal to the district court, Court of Appeals, or Supreme Court. Provision of eligibility by MNsure pending appeal does not render moot MNsure's position in a court of law.

Subd. 7. **Agreements; consultation.** (a) The board shall:

(1) 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;

(2) 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

(3) 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.

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(c) The board shall consult with Indian tribes and organizations regarding the operation of MNsure.

(d) Beginning March 15, 2016, 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.** The board may adopt rules to implement any provisions in this chapter using the expedited rulemaking process in section 14.389.

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.

Subd. 11. **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.

62V.051 MNSURE; CONSUMER RETROACTIVE APPOINTMENT OF A NAVIGATOR OR PRODUCER PERMITTED.

Notwithstanding any other law or rule to the contrary, for up to six months after the effective date of the qualified health plan, MNsure must permit a qualified health plan policyholder, who has not designated a navigator or an insurance producer, to retroactively appoint a navigator or insurance producer. MNsure must provide notice of the retroactive appointment to the health carrier. The health carrier must retroactively pay commissions to the insurance producer if the producer can demonstrate that they were certified by MNsure at the time of the original enrollment, were appointed by the selected health carrier at the time of the enrollment, and that an agent of record agreement was executed prior to or at the time of the effective date of the policy. MNsure must adopt a standard form of agent of record agreement for purposes of this section.

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:

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(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 Tennessee 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 Tennessee 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 Tennessee 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.

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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 sunset 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.

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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. 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.

144.058 INTERPRETER SERVICES QUALITY INITIATIVE.

(a) The commissioner of health shall establish a voluntary statewide roster, and develop a plan for a registry and certification process for interpreters who provide high quality, spoken language health care interpreter services. The roster, registry, and certification process shall be based on the findings and recommendations set forth by the Interpreter Services Work Group required under Laws 2007, chapter 147, article 12, section 13.

(b) By January 1, 2009, the commissioner shall establish a roster of all available interpreters to address access concerns, particularly in rural areas.

(c) By January 15, 2010, the commissioner shall:

(1) develop a plan for a registry of spoken language health care interpreters, including:

(i) development of standards for registration that set forth educational requirements, training requirements, demonstration of language proficiency and interpreting skills, agreement to abide by a code of ethics, and a criminal background check;

(ii) recommendations for appropriate alternate requirements in languages for which testing and training programs do not exist;

(iii) recommendations for appropriate fees; and

(iv) recommendations for establishing and maintaining the standards for inclusion in the registry; and

(2) develop a plan for implementing a certification process based on national testing and certification processes for spoken language interpreters 12 months after the establishment of a national certification process.

(d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper Midwest Translators and Interpreters Association for advice on the standards required to plan for the development of a registry and certification process.

(e) The commissioner shall charge an annual fee of \$50 to include an interpreter in the roster. Fee revenue shall be deposited in the state government special revenue fund.

149A.92 PREPARATION AND EMBALMING ROOM.

Subd. 11. **Scope.** Notwithstanding the requirements in section 149A.50, this section applies only to funeral establishments where human remains are present for the purpose of preparation and embalming, private viewings, visitations, services, and holding of human remains while awaiting final disposition. For the purpose of this subdivision, "private viewing" means viewing of a dead human body by persons designated in section 149A.80, subdivision 2.

179A.50 REPRESENTATION OF FAMILY CHILD CARE PROVIDERS.

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Sections 179A.50 to 179A.52 shall be known as the Family Child Care Providers Representation Act.

179A.51 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 179A.50 to 179A.52, the terms in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of mediation services.

Subd. 3. **Exclusive representative.** "Exclusive representative" means an employee organization that has been elected and certified under section 179A.52, thereby maintaining the right to represent family child care providers in their relations with the state.

Subd. 4. **Family child care provider.** "Family child care provider" means an individual, either licensed or unlicensed, who provides legal child care services as defined under section 245A.03, except for providers licensed under Minnesota Rules, chapter 9503, or excluded from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), and who receives child care assistance to subsidize child care services for a child or children currently in the individual's care, under sections 119B.03; 119B.05; and 119B.011, subdivisions 20 and 20a.

179A.52 RIGHT TO ORGANIZE.

Subdivision 1. **Rights of individual providers and participants.** For the purposes of the Public Employment Labor Relations Act, under chapter 179A, family child care providers shall be considered, by virtue of this section, executive branch state employees employed by the commissioner of management and budget or the commissioner's representative. This section does not require the treatment of family child care providers as public employees for any other purpose. Family child care providers are not state employees for purposes of section 3.736. Chapter 179A shall apply to family child care providers except as otherwise provided in this section. Notwithstanding section 179A.03, subdivision 14, paragraph (a), clause (5), chapter 179A shall apply to family child care providers regardless of part-time or full-time employment status. Family child care providers shall not have the right to strike.

Subd. 2. **Appropriate unit.** The only appropriate unit under this section shall be a statewide unit of all family child care providers who meet the definition in section 179A.51, and who have had an active registration under chapter 119B within the previous 12 months. The unit shall be treated as an appropriate unit under section 179A.10, subdivision 2.

Subd. 3. **Compilation of list.** The commissioner of human services shall, by July 1, 2013, and monthly thereafter, compile and maintain a list of the names and addresses of all family child care providers who meet the definition in section 179A.51, and who have had an active registration under chapter 119B within the previous 12 months. The list shall not include the name of any participant, or indicate that an individual provider is a relative of a participant or has the same address as a participant. The commissioner of human services shall share the lists with others as needed for the state to meet its obligations under chapter 179A as modified and made applicable to family child care providers under this section, and to facilitate the representational processes under this section.

Subd. 4. **List access.** Beginning July 1, 2013, upon a showing made to the commissioner of the Bureau of Mediation Services by any employee organization wishing to represent the appropriate unit of family child care providers that at least 500 family child care providers support such representation, the commissioner of human services shall provide to such organization within seven days the most recent list of actively registered family child care providers compiled under subdivision 3, and subsequent monthly lists upon request for an additional three months. When the list is made available to an employee organization under this subdivision, the list must be made publicly available.

Subd. 5. **Elections for exclusive representative.** After July 31, 2013, any employee organization wishing to represent the appropriate unit of family child care providers may seek exclusive representative status pursuant to section 179A.12. Certification elections for family child care providers shall be conducted by mail ballot, and such election shall be conducted upon an appropriate petition stating that at least 30 percent of the appropriate unit wishes to be represented by the petitioner. The family child care providers eligible to vote in any such election shall be those family child care providers on the monthly list of family child care providers compiled under this section, most recently preceding the filing of the election petition. Except as otherwise provided, elections under this subdivision shall be conducted in accordance with section 179A.12.

Subd. 6. **Meet and negotiate.** If the commissioner certifies an employee organization as the majority exclusive representative, the state, through the governor or the governor's designee,

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shall meet and negotiate in good faith with the exclusive representative of the family child care provider unit regarding grievance issues, child care assistance reimbursement rates under chapter 119B, and terms and conditions of service, but this obligation does not compel the state or its representatives to agree to a proposal or require the making of a concession. The governor or the governor's designee is authorized to enter into agreements with the exclusive representative. Negotiated agreements and arbitration decisions must be submitted to the legislature to be accepted or rejected in accordance with sections 3.855 and 179A.22.

Subd. 7. **Meet and confer.** The state has an obligation to meet and confer under chapter 179A with family child care providers to discuss policies and other matters relating to their service that are not terms and conditions of service.

Subd. 8. **Terms and conditions of service.** For purposes of this section, "terms and conditions of service" has the same meaning as given in section 179A.03, subdivision 19.

Subd. 9. **Rights.** Nothing in this section shall be construed to interfere with:

(1) parental rights to select and deselect family child care providers or the ability of family child care providers to establish the rates they charge to parents;

(2) the right or obligation of any state agency to communicate or meet with any citizen or organization concerning family child care legislation, regulation, or policy; or

(3) the rights and responsibilities of family child care providers under federal law.

Subd. 10. **Membership status and eligibility for subsidies.** Membership status in an employee organization shall not affect the eligibility of a family child care provider to receive payments under, or serve a child who receives payments under, chapter 119B.

179A.53 NO USE OF SCHOLARSHIPS FOR DUES OR FEES.

Early learning scholarships shall not be applied, through state withholding or otherwise, toward payment of dues or fees that are paid to exclusive representatives of family child care providers.

7700.0010 APPLICABILITY AND PURPOSE.

Subpart 1. **Applicability.** Parts 7700.0010 to 7700.0090 apply to an eligible entity that is an applicant to be certified to deliver consumer assistance services through MNsure.

Subp. 2. **Purpose.** Parts 7700.0010 to 7700.0090 establish the policies and procedures for certification as a consumer assistance partner through MNsure.

7700.0020 DEFINITIONS.

Subpart 1. **Scope.** As used in this chapter, the terms defined in this part have the meanings given them.

Subp. 2. **Affordable Care Act.** "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as further defined through amendments to the act and regulations issued under the act.

Subp. 3. **Applicable staff.** "Applicable staff" means any person who has access authorized under this chapter to data stored in the MNsure Web tool.

Subp. 4. **Board.** "Board" means the Board of MNsure specified in Minnesota Statutes, section 62V.04.

Subp. 5. **Certified application counselor.** "Certified application counselor," described in Code of Federal Regulations, title 45, part 155.225, means any entity certified by MNsure to provide consumer assistance services without any compensation from MNsure.

Subp. 6. **Conflict of interest.** "Conflict of interest" means any business, private, or personal interest sufficient to influence or appear to influence the objective execution of an entity's or individual's official or professional responsibilities to the extent necessary to carry out the functions of MNsure.

Subp. 7. **Consumer assistance partner.** "Consumer assistance partner" means entities certified by MNsure to serve as a navigator, in-person assister, or certified application counselor.

Subp. 8. **Cost-sharing reduction.** "Cost-sharing reduction" means reductions in cost sharing for an eligible individual enrolled in a silver level plan through MNsure or for an individual who is an American Indian or Alaska Native enrolled in a QHP through MNsure.

Subp. 9. **Enrollment.** "Enrollment" means enrolling individuals in a QHP or public health care program through MNsure, including properly utilizing the appropriate system tools, resources, and data to perform this function.

Subp. 10. **Individual tax credit.** "Individual tax credit" means premium tax credits specified in section 36B of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act, which are provided on an advance basis to an eligible individual enrolled in a QHP through MNsure according to sections 1402 and 1412 of the Affordable Care Act.

Subp. 11. **In-person assister.** "In-person assister" means any entity certified by MNsure to provide services consistent with the applicable requirements of Code of Federal Regulations, title 45, part 155.205,(c), (d), and (e), and is distinct from a navigator.

Subp. 12. **Insurance producer.** "Insurance producer" has the meaning defined in Minnesota Statutes, section 60K.31.

Subp. 13. **MNsure.** "MNsure" means the "Minnesota Insurance Marketplace" under Minnesota Statutes, chapter 62V, created as a 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.

Subp. 14. **Navigator.** "Navigator" means any entity certified by MNsure to serve as a navigator and has the meaning described in section 1311(i) of the federal Patient Protection and Affordable Care Act (ACA), Public Law 111-148, and further defined through amendments to the act and regulations issued under the act. For calendar year 2014, the navigator program shall be covered by Minnesota Statutes, section 256.962.

Subp. 15. **Qualified health plan or QHP.** "Qualified health plan" or "QHP" 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 according to Minnesota Statutes, section 62V.05, subdivision 5, to be offered through MNsure.

7700.0030 ELIGIBILITY REQUIREMENTS; CERTIFIED CONSUMER ASSISTANCE PARTNERS.

Subpart 1. **Federal prohibitions.**

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A. Consumer assistance partners must not be health insurance issuers, subsidiaries of a health insurance issuer, stop loss insurance issuers, subsidiaries of a stop loss insurance issuer, or professional associations that include members of or lobby on behalf of the insurance industry according to federal requirements in Code of Federal Regulations, title 45, section 155.210 (d).

B. Consumer assistance partners must not have a conflict of interest while serving as a consumer assistance partner.

(1) Consumer assistance partners must not receive any compensation directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees in a qualified health plan or a nonqualified health plan as specified in Code of Federal Regulations, title 45, section 155.210 (d)(4).

(2) Consumer assistance partners must follow the requirements pursuant to Minnesota's Level One Establishment Notice of Grant Award, Special Terms and Conditions, Attachment B, #19: "In order to provide services that meet the requirements of Code of Federal Regulations, title 45, sections 155.205 (d)-(e), and 155.405, individuals performing in-person assistance functions must operate in a fair and impartial manner and must meet and adhere to appropriate conflict of interest standards which include, but are not limited to the following: Do not receive any direct or indirect compensation from an issuer in connection with enrolling consumers in health plans; and are not subsidiaries of an issuer or associations that include members of, or lobby on behalf of, the insurance industry."

Subp. 2. Qualifications.

A. Consumer assistance partners must demonstrate the ability to carry out those responsibilities as defined by the board.

B. Consumer assistance partners must:

(1) demonstrate proven connections to the communities MNsure will serve, or demonstrate the ability to form relationships with consumers, including uninsured and underinsured consumers;

(2) successfully complete MNsure's certification training program; and

(3) comply with any privacy and security standards applicable to MNsure.

Subp. 3. Eligible entities. Consumer assistance partners eligible for certification by MNsure are any of the following entities able to demonstrate to the board that the entity has existing relationships, or could readily establish relationships with consumers in Minnesota, including uninsured, underinsured, and vulnerable populations, likely to be eligible to enroll through MNsure: 501(c)(3) community-based organizations, for-profit businesses, government agencies, and any other entity recognized by the Office of the Secretary of State including, but not limited to:

A. community and consumer-focused nonprofit groups;

B. trade, industry, and professional associations;

C. farming organizations;

D. religious organizations;

E. chambers of commerce;

F. insurance producers, subject to subpart 1;

G. tribal organizations; and

H. state or local human services agencies.

MNsure will consider coalitions or collaboratives of entities meeting the requirements of subpart 3.

**7700.0040 RESPONSIBILITIES OF CONSUMER ASSISTANCE PARTNERS;
CONSUMER ASSISTANCE SERVICES.**

Subpart 1. Duties and responsibilities. As required in Code of Federal Regulations, title 45, section 155.210 (e), consumer assistance partners, at a minimum, must perform the following activities:

A. maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities;

B. provide information and services in a fair, accurate, and impartial manner, and this information must acknowledge other health programs;

C. facilitate enrollment in qualified health plans offered in MNsure;

D. provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate state agency or agencies for any enrollee with a grievance, complaint,

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or question regarding an enrollee's health plan, coverage, or a determination under such plan or coverage;

E. provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by MNsure including individuals with limited English proficiency; and ensure accessibility and usability of tools and functions for individuals with disabilities according to the Americans with Disabilities Act and section 504 of the Rehabilitation Act; and

F. comply with Title VI of the Civil Rights Act of 1964, section 1557 of the Americans with Disabilities Act, and other applicable federal law and regulation.

Subp. 2. **Consumer assistance services.** Consumer assistance partners and insurance producers certified by MNsure shall guide consumers through the application and enrollment process and facilitate access to the range of health coverage options available through MNsure by providing the following services, including but not limited to:

A. informing consumers of health insurance options and the value of coverage, in addition to reviewing insurance options available through MNsure;

B. informing individuals of application processes, required documentation, mandated requirements, and any exemption criteria;

C. providing information and referrals to small employers on enrollment in the Small Business Health Options Program (SHOP) and any tax provisions, including credits and penalties, potentially affecting small employers;

D. gauging eligibility through MNsure and providing referrals to appropriate support services or programs for further assistance, such as free health clinics;

E. providing nonmedical referrals, to the extent possible, according to MNsure referral guidance;

F. explaining program eligibility rules and providing application assistance for Medicaid/CHIP, premium tax credits, and cost-sharing reductions;

G. assisting with the entry of information into enrollment tools and resources, including final submission of information;

H. advising American Indians and Alaskan Natives on benefits specified by the Affordable Care Act, such as cost-sharing reductions, income exclusions, special open enrollment periods, and exemption from minimum health care coverage mandate;

I. addressing questions regarding the submission of eligibility and enrollment verification documentation;

J. facilitating referrals to insurance producers for individuals and families enrolling in qualified health plans through MNsure and requesting plan enrollment assistance beyond the scope of consumer assistance partners;

K. facilitating referrals to community organizations, counties, or other appropriate nonprofit or public entities when individuals and families require technical expertise and assistance beyond the scope of the consumer assistance partner or insurance producer;

L. explaining, discussing, and interpreting coverage and policies with consumers to facilitate plan selection; and

M. assisting with plan comparison based upon individual priorities, including but not limited to metal tier levels, quality ranges, providers including, but not limited to, specialty care, pharmaceutical, dental and eye care, and total cost estimation including utilization and health status.

Regardless of services listed in this subpart, no consumer assistance partner may provide a service that requires licensure under Minnesota Statutes, chapter 60K, unless the consumer assistance partner has the appropriate licensure under Minnesota Statutes, chapter 60K.

7700.0050 CERTIFICATION TRAINING.

Subpart 1. **Consumer assistance partners.** MNsure shall develop a certification training program, administer Web-based training, and administer assessment of proficiency for navigators, in-person assisters, and certified application counselors. Training shall be made available to eligible entities by MNsure. MNsure may enter into agreements with third-party entities to deliver the MNsure certification training program curriculum. MNsure may audit any third-party entity program at any time and may terminate the training agreement at MNsure's discretion. Documentation of certification training completion shall be maintained by MNsure. To receive and maintain MNsure certification, all applicable staff of an entity serving as a navigator,

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in-person assister, or certified application counselor must complete the following required training modules with a minimum passing score, determined by MNsure, on all assigned training coursework. Modules include, but are not limited to, those specified in items A to E.

A. MNsure Web tool that includes training on the use of the public Web site, online enrollment tools, and navigation of the navigator, in-person assister, or certified application counselor landing page.

B. Affordable Care Act 101 that includes training on basic information on available public health care programs, referrals to other consumer assistance partners and insurance producers certified by MNsure, underserved and vulnerable populations, privacy and security as specified in part 7700.0080, and conflict of interest as specified in part 7700.0070.

C. Public health care programs, premium tax credits, and cost-sharing reductions includes training on eligibility and enrollment rules and procedures, and means of appeal and dispute resolution.

D. Qualified health plan includes training on eligibility and enrollment rules and procedures, the range of qualified health plan options offered through MNsure, and the means of appeal and dispute resolution.

E. Overview of Minnesota licensure requirements to sell, solicit, or negotiate insurance.

Subp. 2. **Insurance producers.** MNsure shall establish minimum certification training standards for insurance producers certified to serve by MNsure. Training and assessment of proficiency for insurance producers shall be administered by MNsure. MNsure may enter into agreements with third-party entities to deliver the MNsure certification training program curriculum. MNsure may audit any third-party entity program at any time and may terminate the training agreement at MNsure's discretion. Training shall be made available to eligible insurance producers by MNsure. To receive and maintain MNsure certification, all applicable staff of an entity serving as a certified insurance producer must complete the required training modules in items A to E with a minimum passing score, determined by the board, on all assigned training coursework. Modules include, but are not limited to:

A. MNsure Web tool that includes training on the use of the public Web site, online enrollment tools, and navigation of the insurance producer landing page;

B. Affordable Care Act 101 that includes training on basic information on available public health care programs, referrals to consumer assistance partners serving MNsure, underserved and vulnerable populations, privacy and security as specified in part 7700.0080, and conflict of interest as specified in part 7700.0070;

C. public health care programs, premium tax credits, and cost-sharing reductions includes training on eligibility and enrollment rules and procedures, and the means of appeal and dispute resolution;

D. qualified health plans includes training on eligibility and enrollment rules and procedures, the range of qualified health plan options offered in MNsure, and the means of appeal and dispute resolution; and

E. defined contributions includes training on federal requirements and MNsure online enrollment tools for small employers to provide a defined contribution towards a qualified health plan for their employees.

7700.0060 CERTIFICATION.

Subpart 1. **Consumer assistance partners.** Before providing any services, a navigator, in-person assister, or certified application counselor must be certified by MNsure by meeting the criteria in items A to F:

A. enter into a formal agreement with MNsure by responding to MNsure's solicitation for navigators, in-person assisters, or certified application counselors;

B. select, manage, and monitor individuals performing consumer assistance services and direct them to meet MNsure certification training standards by ensuring that all applicable staff participate in required MNsure sponsored training under part 7700.0050;

C. comply with MNsure conflict of interest standards as specified in part 7700.0070;

D. comply with MNsure privacy and security standards as specified in part 7700.0080;

E. comply with MNsure account creation process; and

F. comply with recertification requirements to be determined by MNsure.

Subp. 2. **Insurance producers.** Before providing any services through MNsure, an insurance producer must be certified by MNsure by meeting the criteria in items A to G:

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- A. maintain active status as an insurance producer under part 7700.0020, subpart 12;
- B. inform MNsure of the intent to be certified by MNsure;
- C. ensure that all insurance producer and applicable staff and subcontractors participate in required MNsure certification training specified in part 7700.0050;
- D. disclose to MNsure which health carrier's qualified health plans offered through MNsure the insurance producer is authorized to sell;
- E. comply with MNsure privacy and security standards specified in part 7700.0080;
- F. comply with the MNsure account creation process; and
- G. comply with recertification requirements to be determined by MNsure.

Subp. 3. **Noncompliance.** At MNsure's discretion, certification may be withdrawn from a navigator, in-person assister, certified application counselor or individual for noncompliance with the certification requirements in subpart 1. At MNsure's discretion, certification may be withdrawn from an insurance producer entity or individual for noncompliance with the certification requirements in subpart 2.

Subp. 4. **Monitored performance.** At MNsure's discretion, a consumer assistance partner and MNsure certified insurance producer's performance may be monitored during the certification period. MNsure may require an underperforming entity to develop and implement a time-limited performance improvement plan. If performance is not to MNsure's satisfaction, certification to provide services through MNsure may be withdrawn.

7700.0070 CONFLICT OF INTEREST.

Subpart 1. **Framework; consumer assistance partners.** MNsure shall provide consumers with impartial, high-quality, community-based education and information, and in-person application and enrollment assistance through consumer assistance partners. In order to ensure the delivery of high quality services, to minimize or eliminate the existence of conflicts of interest and ensure integrity, MNsure will:

- A. screen for potential conflicts of interest during the consumer assistance partner selection process and throughout the term of engagement with these entities;
- B. require initial and ongoing training that includes instruction on providing impartial education and in-person assistance with consumer selection of a qualified health plan;
- C. require the consumer assistance partner to disclose all affiliations that may present a direct, indirect, or perceived conflict of interest which includes submission of a written attestation that the consumer assistance partner is not a health insurance issuer or issuer of stop loss insurance, a subsidiary of a health insurance issuer or issuer of stop loss insurance, or an association that includes members of, or lobbies on behalf of, the insurance industry;
- D. monitor the consumer assistance partner's performance and practice through reporting;
- E. monitor the consumer assistance partner through feedback tools on the MNsure Web site and through qualitative and quantitative evaluation tools;
- F. actively solicit customer satisfaction feedback on experience with MNsure; and
- G. as circumstances command, where a conflict of interest arises, require mitigation, revocation of certification, or termination of partnership with a consumer assistance partner.

Subp. 2. **Insurance producers.** All current conflict of interest requirements in Minnesota Rules and Minnesota Statutes shall apply to insurance producers.

7700.0080 PRIVACY AND SECURITY.

Pursuant to Code of Federal Regulations, title 45, part 155.260, MNsure shall require a navigator, in-person assister, certified application counselor, or insurance producer to annually attest that its data security and privacy practices are compliant with the applicable federal and state laws and supportive of MNsure data security and privacy practices. Any navigator, in-person assister, certified application counselor, or insurance producer must have specific authorization from MNsure prior to accessing data through MNsure according to Minnesota Statutes, section 62V.06, subdivision 8. The authorization must be immediately and permanently revoked under Minnesota Statutes, section 62V.06, subdivision 8, for any willful violation of Minnesota Statutes, chapter 13. MNsure has the right to inspect, assess, and audit a navigator, in-person assister, certified application counselor, or insurance producer's data security and privacy practices. Inadequate data security and privacy practices may result in termination of certification at the discretion of MNsure.

7700.0090 COMPENSATION.

Subpart 1. **Consumer assistance partners compensation.** Consumer assistance partner compensation may include, but is not limited to, per enrollment payments, grants, and pay-for-performance payments. The type of compensation is dependent on the specific role of the consumer assistance partner. The amount or rate of compensation is dependent on the specific role of the consumer assistance partner. The rate of per enrollment payments shall be set by the board on an annual basis. The initial payment rate and any subsequent changes to the payment rate must be published in the State Register. The payment rate is effective upon publication and applicable for all work completed on or after the payment rate effective date.

A. Payment per enrollment.

(1) Consumer assistance partners may receive payment for each successful enrollment through MNsure. The rate of payment shall be set by MNsure. The initial payment rate and any subsequent changes to the payment rate shall be published in the State Register. The payment rate is effective upon publication and applicable for all work completed on or after the payment rate effective date. Payments shall be paid based on the availability of funding.

(2) Payments shall be made directly to the entity.

B. Grants.

(1) MNsure may award grants through a competitive process. The competitive process shall be based on solicitation, and at MNsure's discretion, grants shall be established based on the criteria outlined in the solicitation.

(2) Disbursements of grant funding shall be paid per contract agreed to between the entity and MNsure.

C. Pay-for-performance payments. At the discretion of MNsure, pay-for-performance payments shall be established to address specific performance measures including, but not limited to, targeted geographic areas, specific population barriers, disparities, or distinctive outreach activities.

Subp. 2. **Insurance producers.** Compensation for insurance producers is subject to Minnesota Statutes, section 62V.05, subdivision 3.

7700.0100 ADMINISTRATIVE REVIEW OF MNSURE ELIGIBILITY DETERMINATIONS.

Subpart 1. **Applicability.** Parts 7700.0100 to 7700.0105 govern the administration of MNsure eligibility appeals. Parts 7700.0100 to 7700.0105 must be read in conjunction with the federal Affordable Care Act, Public Law 111-148; Code of Federal Regulations, title 45, part 155; and Minnesota Statutes, chapter 62V; and sections 256.045 and 256.0451.

Subp. 2. **Applicability to medical assistance and MinnesotaCare.** Although MNsure offers a unique single marketplace for consumers to compare several health insurance coverage options, including coverage under medical assistance and MinnesotaCare, appeals rights and processes for medical assistance and MinnesotaCare are found in applicable federal or state statute or rule, including, but not limited to, parts 9505.0130, 9505.5105, 9505.0545, and 9506.0070, and Minnesota Statutes, sections 256.045, 256.0451, and 256L.10. Nothing in these rules should be construed to supersede, abridge, or in any way limit the appeal rights of appellants contesting issues covered or not covered under these rules that are available under applicable federal or state statute or rule, including, but not limited to, parts 9505.0130, 9505.5105, 9505.0545, and 9506.0070, and Minnesota Statutes, sections 256.045, 256.0451, and 256L.10. However, nothing in these rules prevent any MNsure consumer from filing appeals through MNsure.

Subp. 3. **Regulatory investigations.** Nothing in these rules limits or supersedes the ability of the commissioners of commerce and health to conduct investigations or facilitate appeals as authorized by laws administered by the Departments of Commerce and Health.

7700.0101 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 7700.0100 to 7700.0105, the terms defined in this part have the meanings given them.

Subp. 2. **Agency.** "Agency" means the entity that made the eligibility determination being contested. Agency includes MNsure and, where applicable, any entity involved under a contract, subcontract, grant, or subgrant with MNsure that provides or operates programs or services for which appeals are available. Agency does not include the Minnesota Department of Commerce or the Minnesota Department of Health.

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Subp. 3. **Appeal.** "Appeal" means a challenge to or dispute of an initial determination or redetermination made by MNSure enumerated under part 7700.0105, subpart 1, item A.

Subp. 4. **Appeal record.** "Appeal record" means all relevant records pertaining to the contested issues, including eligibility records filed in the proceeding, the appeal decision, all papers and requests filed in the proceeding, and if a hearing is held, the recording of the hearing testimony or an official report containing the substance of what happened at the hearing and any exhibits introduced at the hearing.

Subp. 5. **Appeals examiner.** "Appeals examiner" means a person appointed to conduct hearings under this part by the MNSure board and includes human services judges of the Department of Human Services and administrative law judges of the Office of Administrative Hearings, when acting under a delegation of authority from the MNSure board.

Subp. 6. **Appellant.** "Appellant" means the applicant or enrollee, the employer, or small business employer or employee submitting an appeal. Appellant includes the appellant's attorney or representative. An appellant who is not a business owner may file and appeal on his or her own behalf or on behalf of the appellant's household.

Subp. 7. **Business day.** "Business day" means any day other than a Saturday, Sunday, or legal holiday as defined in Minnesota Statutes, section 645.44.

Subp. 8. **Business hours.** "Business hours" means the hours between 8:30 a.m. and 4:30 p.m., Central Standard Time, on business days.

Subp. 9. **Chief appeals examiner.** "Chief appeals examiner" means the chief human services judge of the Department of Human Services and the chief administrative law judge of the Office of Administrative Hearings, when acting under a delegation of authority from the MNSure board.

Subp. 10. **De novo review.** "De novo review" means a review of an appeal without deference to prior decisions in the case and can include making new findings of fact based on the appeal record.

Subp. 11. **Eligibility.** "Eligibility" means meeting the stipulated requirements for participation in a program or access to a service or product.

Subp. 12. **MNSure board or board.** "MNSure board" or "board" means the entity established in Minnesota Statutes, chapter 62V, as a board under Minnesota Statutes, section 15.012, and should be understood to include any individual or entity to whom the board has delegated a specific power or authority either directly or through an interagency agreement when that individual or entity is exercising the delegation.

Subp. 13. **Party or parties.** "Party" or "parties" means the appellants and agencies that are involved in an appeal and who have the legal right to make claims and defenses, offer proof, and examine and cross-examine witnesses during the appeal.

Subp. 14. **Person.** "Person" means a natural person.

Subp. 15. **Preponderance of the evidence.** "Preponderance of the evidence" means, in light of the record as a whole, the evidence leads the appeals examiner to believe that the finding of fact is more likely to be true than not true.

Subp. 16. **Representative.** "Representative" means a person who is empowered by the party to support, speak for, or act on behalf of the party. Representative includes legal counsel, relative, friend, or other spokesperson or authorized representative under Code of Federal Regulations, title 45, section 155.227.

Subp. 17. **Vacate.** "Vacate" means to set aside a previous action.

7700.0105 MNSURE ELIGIBILITY APPEALS.

Subpart 1. Eligibility.

A. MNSure appeals are available for the following actions:

(1) initial determinations and redeterminations made by MNSure of individual eligibility to purchase a qualified health plan through MNSure, made in accordance with Code of Federal Regulations, title 45, sections 155.305, (a) and (b); 155.330; and 155.335;

(2) initial determinations and redeterminations made by MNSure of eligibility for and level of advance payment of premium tax credit, and eligibility for and level of cost sharing reductions, made in accordance with Code of Federal Regulations, title 45, sections 155.305 (f) to (g); 155.330; and 155.335;

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(3) initial determinations and redeterminations made by MNsure of employer eligibility to purchase coverage for qualified employees through the Small Business Health Options Program under Code of Federal Regulations, title 45, section 155.710 (a);

(4) initial determinations and redeterminations made by MNsure of employee eligibility to purchase coverage through the Small Business Health Options Program under Code of Federal Regulations, title 45, section 155.710 (e);

(5) initial determinations and redeterminations made by MNsure of individual eligibility for an exemption from the individual responsibility requirement made in accordance with Code of Federal Regulations, title 45, section 155.605;

(6) a failure by MNsure to provide timely notice of an eligibility determination in accordance with Code of Federal Regulations, title 45, sections 155.310 (g); 155.330 (e)(1)(ii); 155.335 (h)(ii); 155.610 (i); and 155.715 (e) and (f);

(7) in response to a notice from MNsure under Code of Federal Regulations, title 45, section 155.310 (h), a determination by MNsure that an employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide coverage but is not affordable coverage with respect to an employee; and

(8) in response to a denial of a request to vacate a dismissal made according to this chapter and in accordance with Code of Federal Regulations, title 45, section 155.530 (d)(2).

B. If an individual has been denied eligibility for medical assistance under Code of Federal Regulations, title 45, section 155.302 (b), an appeal of a determination of eligibility for advanced payments of the premium tax credit or cost-sharing reduction must also be treated as an appeal of medical assistance determination of eligibility.

Subp. 2. Filing an appeal.

A. To initiate an appeal, an appellant must file the appeal with MNsure as follows:

- (1) by mail;
- (2) by telephone;
- (3) by Internet; and
- (4) in person.

B. MNsure must provide the necessary contact information for each method of filing an appeal with each eligibility determination and also through the MNsure Web site.

C. The agency must assist any potential appellant in filing an appeal when assistance is requested.

D. An appeal must be received by MNsure within 90 days from the date of the notice of eligibility determination. There is a rebuttable presumption that the date of the notice of eligibility determination is five business days later than the date printed on the notice. The person may rebut this presumption by presenting evidence or testimony that they received the notice five business days after the date printed on the notice. An appeal received more than 90 days after the date of the eligibility notice will be dismissed. If the deadline for filing an appeal falls on a day that is not a business day, the filing deadline is the next business day.

E. Appeal request forms will be available to persons through the Internet, by in-person request, by mail, and by telephone. The following information is requested, but not required, in an appeal:

- (1) name;
- (2) MNsure username;
- (3) date of birth;
- (4) address, including either an e-mail address, if available, or a mailing or physical address;
- (5) MNsure programs involved in the appeal, for which a list must be provided on the appeal request form;
- (6) reason for the appeal; and
- (7) in appeals of redeterminations of eligibility, whether the appellant intends to continue at the level of eligibility and benefits before the redetermination being appealed until the appeal decision.

F. Appeals shall be accepted regardless of whether the requested information is provided on the form or the information is incomplete. However, failure by an appellant to provide all of the requested information may prevent resolution of the appeal or delivery of effective notice.

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G. The date of official receipt of appeals submitted after business hours, whether filed through the Internet or by telephone, is the next business day.

Subp. 3. Notices and communications.

A. The parties to an appeal have the right to the following timely notices and communications:

(1) acknowledgement of receipt of the appeal and a scheduling order, including information regarding the appellant's eligibility pending appeal and an explanation that any advance payments of the premium tax credit paid on behalf of the tax filer pending appeal are subject to reconciliation; and

(2) the decision and order of the MNsure board.

B. Any notice sent to the appellant must also be sent to the appellant's attorney or representative.

C. An appeals examiner shall not have ex parte contact on substantive issues with the agency, the appellant, or any person involved in an appeal. No agency employee shall review, interfere with, change, or attempt to influence the recommended decision of the appeals examiner in any appeal, except through the procedures allowed herein. The limitations in this subpart do not affect the board's authority to review or make final decisions.

Subp. 4. Rescheduling.

A. Requests to reschedule a hearing must be made in person, by telephone, through the Internet, or mailed and postmarked to the appeals examiner at least five days in advance of the regularly scheduled hearing date. The rescheduling request may be made orally or in writing. The requesting party must provide the other party a copy of a written request or must otherwise notify the other party of the request.

B. Any rescheduling of a hearing with less than five days' advance notice will be at the discretion of the appeals examiner and granted only when the rescheduling does not prejudice any party to the rescheduling.

C. Unless a determination is made by the appeals examiner that a request to reschedule a hearing is made for the purpose of delay, a hearing must be rescheduled by the appeals examiner for good cause as determined by the appeals examiner. Good cause includes the following:

(1) to accommodate a witness;

(2) to obtain necessary evidence, preparation, or representation;

(3) to review, evaluate, and respond to new evidence;

(4) to permit negotiations of resolution between the parties;

(5) to permit the agency to reconsider;

(6) to permit actions not previously taken;

(7) to accommodate a conflict of previously scheduled appointments;

(8) to accommodate a physical or mental illness;

(9) where an interpreter, translator, or other service necessary to accommodate a person with a disability is needed but not available; or

(10) any other compelling reasons beyond the control of the party that prevents attendance at the originally scheduled time.

D. If requested by the appeals examiner, a written statement confirming the reasons for the rescheduling request must be provided to the appeals examiner by the requesting party.

Subp. 5. Telephone, videoconference, or in-person hearing.

A. A hearing may be conducted by telephone, videoconference, or in person. An in-person appeals hearing will only be held at the discretion of the appeals examiner, or if the person asserts that either the person or a witness has a physical or mental disability that would impair the person's ability to fully participate in a hearing held by interactive video technology. To have the hearing conducted by videoconference or in person, a person must make a specific request for that type of hearing.

B. When an in-person hearing is granted, the appeals examiner shall conduct the hearing in the county where the person involved resides, unless an alternate location is mutually agreed upon before the hearing.

C. Where federal law or regulation does not require a telephone, videoconference, or in-person hearing and allows for a review of documentary evidence through a desk review, a telephone, videoconference, or in-person hearing will only be provided when the appeals

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examiner determines that such a hearing would materially assist in resolving the issues presented by the appeal.

Subp. 6. Emergency expedited appeals.

A. An appellant has a right to request an emergency expedited appeal when there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function. An appellant must specify that an emergency expedited appeal is being requested when submitting the initial appeal.

B. If an emergency develops during a pending appeal such that there has developed an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function, an appellant may request an expedited appeal.

C. If a request for an expedited appeal is denied, the appellant will be notified according to the process and time period required under the applicable federal law.

D. If a request for an expedited appeal is accepted, the appeals examiner will issue a decision according to the process and time period required under the applicable federal law.

Subp. 7. Interpreter and translation services.

A. Appeals must be accessible to appellants who have limited English proficiency, appellants who require interpreter and translation services, and appellants with disabilities. An appeals examiner has a duty to inquire whether any person involved in the hearing needs the services of an interpreter, translator, or reasonable accommodations to accommodate a disability in order to participate in or to understand the appeal process.

B. Necessary interpreter services, translation services, or reasonable accommodations must be provided at no cost to the person involved in the appeal.

C. If an appellant requests interpreter services, translation services, or reasonable accommodations or it appears to the appeals examiner that necessary interpreter or translation services are needed but not available for the scheduled hearing, the hearing shall be rescheduled to the next available date when the appropriate services can be provided.

Subp. 8. Access to data.

A. Subject to the requirements of all applicable state and federal laws regarding privacy, confidentiality, and disclosure of personally identifiable information, the appellants and agencies involved in an appeals hearing must be allowed to access the appeal record upon request at a convenient place and time before and during the appeals hearing. Copies of the appeal record, including an electronic copy of the recorded hearing, must be provided at no cost and, upon request, must be mailed or sent by electronic transmission to the party or the party's representative.

B. An appellant involved in an appeals hearing may enforce the right of access to data and copies of the case file by making a request to the appeals examiner. The appeals examiner shall make an appropriate order enforcing the appellant's right of access, including but not limited to ordering access to files, data, and documents possessed by the agency; continuing or rescheduling an appeal hearing to allow adequate time for access to data; or prohibiting use by the agency of files, data, or documents that have been generated, collected, stored, or disseminated in violation of the requirements of state or federal law, or when the documents have not been provided to the appellant involved in the appeal.

Subp. 9. Data practices.

A. Data on individuals, as defined in Minnesota Statutes, section 13.02, subdivision 5, will be collected about persons and appellants throughout the appeals process. The purpose of this data collection is to conduct an appeal. A party to an appeal is not required to supply data for an appeal. However, deciding which evidence and testimony to submit may have an impact on the outcome of the appeal decision. Certain other government officials may have access to information provided throughout the appeals process if this is allowed by law or pursuant to a valid court order.

B. When an appeal proceeds beyond the MNsure appeals process to judicial review, the appeal record will be public unless the court with jurisdiction over the appeal issues a protective order. When the appeal proceeds outside of the MNsure appeals process to the United States Department of Health and Human Services, the record will be classified according to federal law governing the collection of data on individuals.

Subp. 10. Appeal summary. The agency must prepare an appeal summary for each appeal hearing. The appeal summary shall be delivered to each party and the MNsure appeals examiner at least three business days before the date of the appeal hearing. The appeals examiner shall confirm

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that the appeal summary is delivered to the party involved in the appeal as required under this subpart. Each party shall be provided, through the appeal summary or other reasonable methods, appropriate information about the procedures for the appeal hearing and an adequate opportunity to prepare. The contents of the appeal summary must be adequate to inform each party of the evidence on which the agency relies and the legal basis for the agency's action or determination.

Subp. 11. **Representation during appeal.** An appellant may personally appear in any appeal hearing and may be represented by an attorney or representative. A partnership may be represented by any of its members, an attorney, or other representative. A corporation or association may be represented by an officer, an attorney, or other representative. In a case involving an unrepresented appellant, the appeals examiner shall examine witnesses and receive exhibits for the purpose of identifying and developing in the appeal record relevant facts necessary for making an informed and fair decision. An unrepresented appellant shall be provided an adequate opportunity to respond to testimony or other evidence presented by the agency at the appeal hearing. The appeals examiner shall ensure that an unrepresented appellant has a full and reasonable opportunity at the appeal hearing to establish a record for appeal. An agency may be represented by an employee or an attorney, including an attorney employed by the agency as authorized by law.

Subp. 12. **Dismissals.**

A. The appeals examiner must dismiss an appeal if the appellant:

- (1) withdraws the appeal orally or in writing;
- (2) fails to appear at a scheduled appeal hearing or prehearing conference and good cause is not shown;
- (3) fails to submit a valid appeal; or
- (4) dies while the appeal is pending.

B. If an appeal is dismissed, the appeals examiner must provide timely notice to the parties, which must include the reason for dismissal, an explanation of the dismissal's effect on the appellant's eligibility, and an explanation of how the appellant may show good cause why the dismissal should be vacated.

C. The appeals examiner must vacate a dismissal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated. There is a rebuttable presumption that the date of the notice of dismissal is five business days later than the date printed on the notice. The person may rebut this presumption by presenting evidence or testimony that they received the notice later than five business days after the date printed on the notice. Good cause can be shown when there is:

- (1) a death or serious illness in the person's family;
- (2) a personal injury or physical or mental illness that reasonably prevents an appellant or witness from attending the hearing;
- (3) an emergency, crisis, including a mental health crisis, or unforeseen event that reasonably prevents an appellant or witness from attending the hearing;
- (4) an obligation or responsibility of an appellant or witness which a reasonable person, in the conduct of one's affairs, could reasonably determine takes precedence over attending the hearing;
- (5) lack of or failure to receive timely notice of the hearing in the preferred language of an appellant involved in the hearing;
- (6) excusable neglect, excusable inadvertence, or excusable mistake as determined by the appeals examiner; or
- (7) any other compelling reason beyond the control of the party as determined by the appeals examiner.

Subp. 13. **Prehearing conferences.**

A. The appeals examiner, at the examiner's discretion, prior to an appeal hearing may hold a prehearing conference to further the interests of justice or efficiency. The parties must participate in any prehearing conference held. A party may request a prehearing conference. The prehearing conference may be conducted by telephone, in writing, or in person. The prehearing conference may address the following issues:

- (1) disputes regarding access to files, evidence, subpoenas, or testimony;
- (2) the time required for the hearing or any need for expedited procedures or decision;
- (3) identification or clarification of legal or other issues that may arise at the hearing;

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(4) identification of and possible agreement to factual issues; and
(5) scheduling and any other matter that will aid in the proper and fair functioning of the hearing.

B. The appeals examiner shall make a record or otherwise contemporaneously summarize the prehearing conference in writing, which shall be sent to:

- (1) the parties; and
- (2) the party's attorney or representative.

Subp. 14. Disqualification of appeals examiner.

A. The chief appeals examiner shall remove an appeals examiner from any case where the appeals examiner believes that presiding over the case would create the appearance of unfairness or impropriety. No appeals examiner may hear any case where any of the parties to the appeal are related to the appeals examiner by blood or marriage. An appeals examiner must not hear any case if the appeals examiner has a financial or personal interest in the outcome. An appeals examiner having knowledge of such a relationship or interest must immediately notify the chief appeals examiner and be removed from the case.

B. A party may move for the removal of an appeals examiner by written application of the party together with a statement of the basis for removal. Upon the motion of the party, the chief appeals examiner must decide whether the appeals examiner may hear the particular case.

Subp. 15. Status of eligibility and benefits pending appeal.

A. In appeals involving a redetermination of an appellant's eligibility, the appellant shall continue at the level of eligibility and benefits before the redetermination being appealed only if the appellant affirmatively elects to receive them during the appeal.

B. The appeal type, as specified in subpart 1, item A, determines what eligibility and benefits are available to be continued pending appeal. The availability of a continuation of eligibility and benefits is only available for appellants under subpart 1, item A, subitems (1) and (2). If appealing eligibility for advanced payments of premium tax credits and/or cost-sharing reductions, at issue is the amount of the advance payments of premium tax credits and/or cost-sharing reductions; and if appealing the eligibility to purchase a QHP through MNsure, at issue is the eligibility to purchase a QHP through MNsure.

C. Where an appellant continues at the level of eligibility before the redetermination being appealed and the appeal decision upholds the redetermination being appealed, the appellant is subject to reconciliation and repayment of any overpayment.

Subp. 16. Commencement and conduct of hearing.

A. The appeals examiner shall begin each hearing by describing the process to be followed in the hearing, including the swearing in of witnesses, how testimony and evidence are presented, the order of examining and cross-examining witnesses, and the opportunity for an opening statement and a closing statement. The appeals examiner shall identify for the parties the issues to be addressed at the hearing and shall explain to the parties the burden of proof that applies to the appellant and the agency. The appeals examiner shall confirm, prior to proceeding with the hearing, that the appeal summary, if prepared, has been properly completed and provided to the parties, and that the parties have been provided documents and an opportunity to review the appeal record, as provided in this part.

B. The appeals examiner shall act in a fair and impartial manner at all times. At the beginning of the appeal hearing, the agency must designate one person as a representative who shall be responsible for presenting the agency's evidence and questioning any witnesses. The appeals examiner shall make sure that both the agency and the appellant are provided sufficient time to present testimony and evidence, to confront and cross-examine all adverse witnesses, and to make any relevant statement at the hearing. All testimony in the hearing will be taken under oath or affirmation. The appeals examiner shall make reasonable efforts to explain the appeal hearing process to unrepresented appellants and shall ensure that the hearing is conducted fairly and efficiently. Upon the reasonable request of the appellant or the agency or at the discretion of the appeals examiner, the appeals examiner shall direct witnesses to remain outside the hearing room, except during individual testimony, when the appeals examiner determines that such action is appropriate to ensure a fair and impartial hearing. The appeals examiner shall not terminate the hearing before affording the appellant and the agency a complete opportunity to submit all admissible evidence and reasonable opportunity for oral or written statement. In the event that an appeal hearing extends beyond the time allotted, the appeal hearing shall be continued from day to day until completion. Appeal hearings that have been continued shall be timely scheduled to minimize delay in the disposition of the appeal.

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C. The appeal hearing shall be a de novo review and shall address the correctness and legality of the agency's action and shall not be limited simply to a review of the propriety of the agency's action. The appellant may raise and present evidence on all legal claims or defenses arising under state or federal law as a basis for the appeal, excluding any constitutional claims that are beyond the jurisdiction of the appeal hearing. The appeals examiner may take official notice of adjudicative facts.

D. The burden of persuasion is governed by specific state or federal law and regulations that apply to the subject of the hearing. Unless otherwise required by specific state or federal laws that apply to the subject of the appeal, the appellant carries the burden to persuade the appeals examiner that a claim is true and must demonstrate such by a preponderance of the evidence.

E. The appeals examiner shall accept all evidence, except evidence privileged by law, that is commonly accepted by reasonable people in the conduct of their affairs as having probative value on the issues to be addressed at the appeal hearing. The appeals examiner shall ensure for all cases that the appeal record is sufficiently complete to make a fair and accurate decision.

F. The agency must present its evidence prior to or at the appeal hearing. The agency shall not be permitted to submit evidence after the hearing except by agreement at the hearing between the appellant, the agency, and the appeals examiner. If evidence is submitted after the appeal hearing, based on an agreement, the appellant and the agency must be allowed sufficient opportunity to respond to the evidence. When determined necessary by the appeals examiner, the appeal record shall remain open to permit an appellant to submit additional evidence on the issues presented at the appeal hearing.

Subp. 17. **Orders of the MNsure board.**

A. A timely, written decision must be issued in every appeal. Each decision must contain a clear ruling on the issues presented in the appeal hearing and contain a ruling only on questions directly presented by the appeal and the arguments raised in the appeal.

B. A written decision must be issued within 90 days of the date the appeal is received, as administratively feasible, unless a shorter time is required by law.

C. The decision must contain both findings of fact and conclusions of law, clearly separated and identified. The findings of fact must be based on the entire appeal record. Each finding of fact made by the appeals examiner shall be supported by a preponderance of the evidence unless a different standard is required by law. The legal claims or arguments of a participant do not constitute either a finding of fact or a conclusion of law, except to the extent the appeals examiner explicitly adopts an argument as a finding of fact or conclusion of law.

D. The decision shall contain at least the following:

(1) a listing of the date and place of the appeal hearing and the parties and persons appearing at the appeal hearing;

(2) a clear and precise statement of the issues, including the dispute that is the subject of the appeal and the specific points that must be resolved in order to decide the case;

(3) a listing of each of the materials constituting the appeal record that were placed into evidence at the appeal hearing, and upon which the appeal hearing decision is based;

(4) the findings of fact based upon the entire appeal record. The findings of fact must be adequate to inform the parties and the public of the basis of the decision. If the evidence is in conflict on an issue that must be resolved, the findings of fact must state the reasoning used in resolving the conflict;

(5) conclusions of law that address the legal authority for the appeal hearing and the ruling, and which give appropriate attention to the claims of the parties;

(6) a clear and precise statement of the decision made resolving the dispute that is the subject of the appeal, including the effective date of the decision; and

(7) written notice of any existing right to appeal, including taking an appeal to the United States Department of Health and Human Services and identifying the time frame for an appeal and that the decision is final unless appealed.

E. The appeals examiner shall not independently investigate facts or otherwise rely on information not presented at the appeal hearing. The appeals examiner may not contact other agency personnel, except as provided in subpart 16. The appeals examiner's recommended decision must be based exclusively on the testimony and evidence presented at the appeal hearing, legal arguments presented, and the appeals examiner's research and knowledge of the law.

F. The MNsure board shall review the recommended decision and accept or refuse to accept the decision. The MNsure board may accept the recommended order of an appeals

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examiner and issue the order to the parties or may refuse to accept the decision. Upon refusal, the MNsure board shall notify the parties of the refusal, state the reasons, and allow each party ten days to submit additional written argument on the matter. After the expiration of the ten-day period, the MNsure board shall issue an order on the matter to the parties. Refusal of the MNsure board to accept a decision must not delay the 90-day time limit to issue a decision.

Subp. 18. **Public access to hearings and decisions.** Appeal decisions must be maintained in a manner so that the public has ready access to previous decisions on particular topics, subject to appropriate procedures for compliance with applicable state and federal laws regarding the privacy, confidentiality, and disclosure, of personally identifiable information. Appeal hearings conducted under this part are not open to the public due to the not public classification of the information provided for inclusion in the appeal record.

Subp. 19. **Administrative review.**

A. Administrative review by the United States Department of Health and Human Services may be available for parties aggrieved by an order of the MNsure board.

B. An appeal under this part must be filed with the United States Department of Health and Human Services and MNsure within 30 days of the date of the appeal decision according to the process required under the applicable federal regulations.

Subp. 20. **Judicial review.** An appellant may seek judicial review to the extent it is available by law.